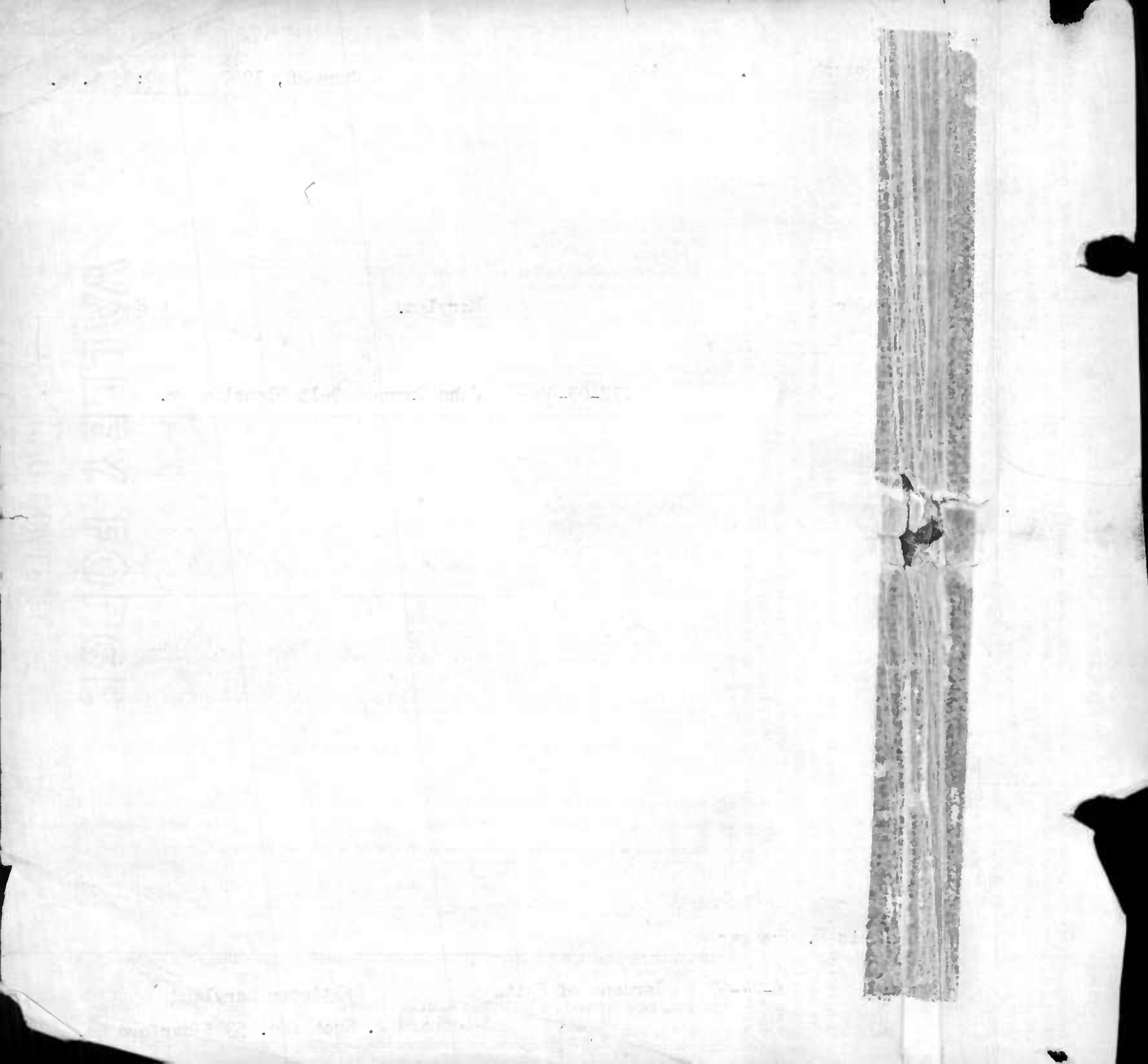


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

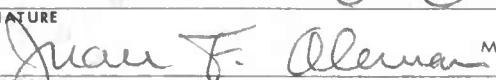
Baltimore City Health Department				Registered No. 67 6001	
BIRTH NO. 67 6001		<b>CERTIFICATE OF DEATH</b>		DATE AND HOUR OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Joseph A. Eich</b>		June 20, 1967 9:35 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Mercy Hospital</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>1-02</b> D. STREET ADDRESS (If rural, give location) <b>4 S. ROBINSON ST.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>5-12-05</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>JOSEPH JAMES EICH</b>		14. MOTHER'S MAIDEN NAME <b>MARY HELFER</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-0465</b>		17. INFORMANT ADDRESS <b>John Curreri 3415 Glenside Dr.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., fracture, asphyxia, etc. It means the disease, or complication which caused death.) <b>Hepatic failure</b>			CAUSE OF DEATH (A) DUE TO <b>Hepatic failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
19. ANTECEDENT CAUSES (Diseases or conditions, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) <b>Nutritional Cirrhosis</b>			(B) DUE TO <b>Nutritional Cirrhosis</b>		<b>years</b>
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Duodenal ulcer &amp; hemorrhage Chronic obstructive airway disease, ASCVD</b>					
19A. DATE OF OPERATION <b>5-11-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bleeding duodenal ulcer</b>		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 3 19 67</b> to <b>June 20 19 67</b> , that (we) lost saw the deceased alive on <b>June 20 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Louis E. Grenzer</b>				23B. DATE SIGNED <b>6-20-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Louis E. Grenzer</b>				23D. ADDRESS <b>Leonard J. Ruck Inc. 5305 Harford</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-24-67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Maryland</b>		24E. (State) <b>Maryland</b>		25C. FUNERAL DIRECTOR ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Bailey</b>		25D. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford</b>	

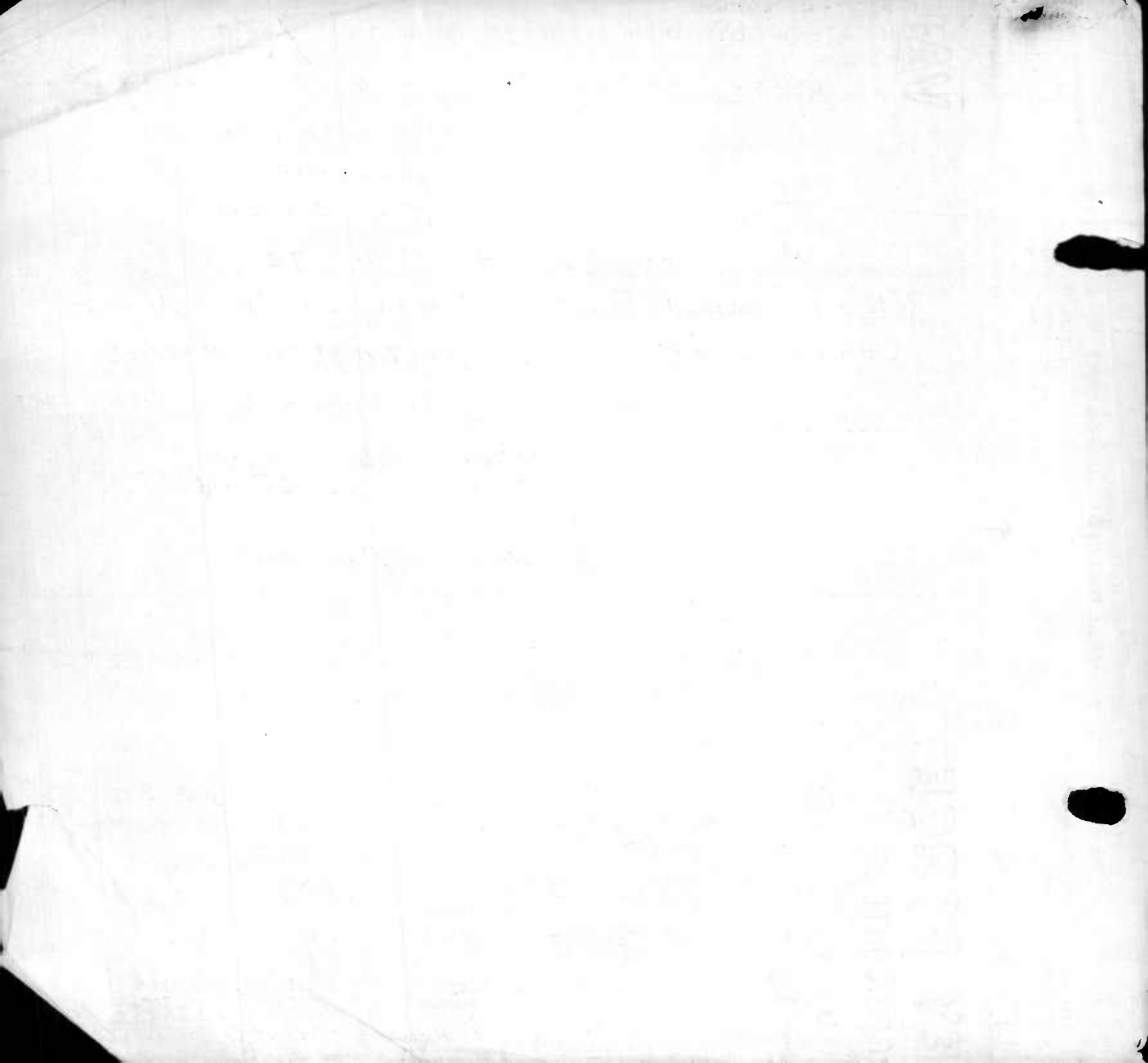




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

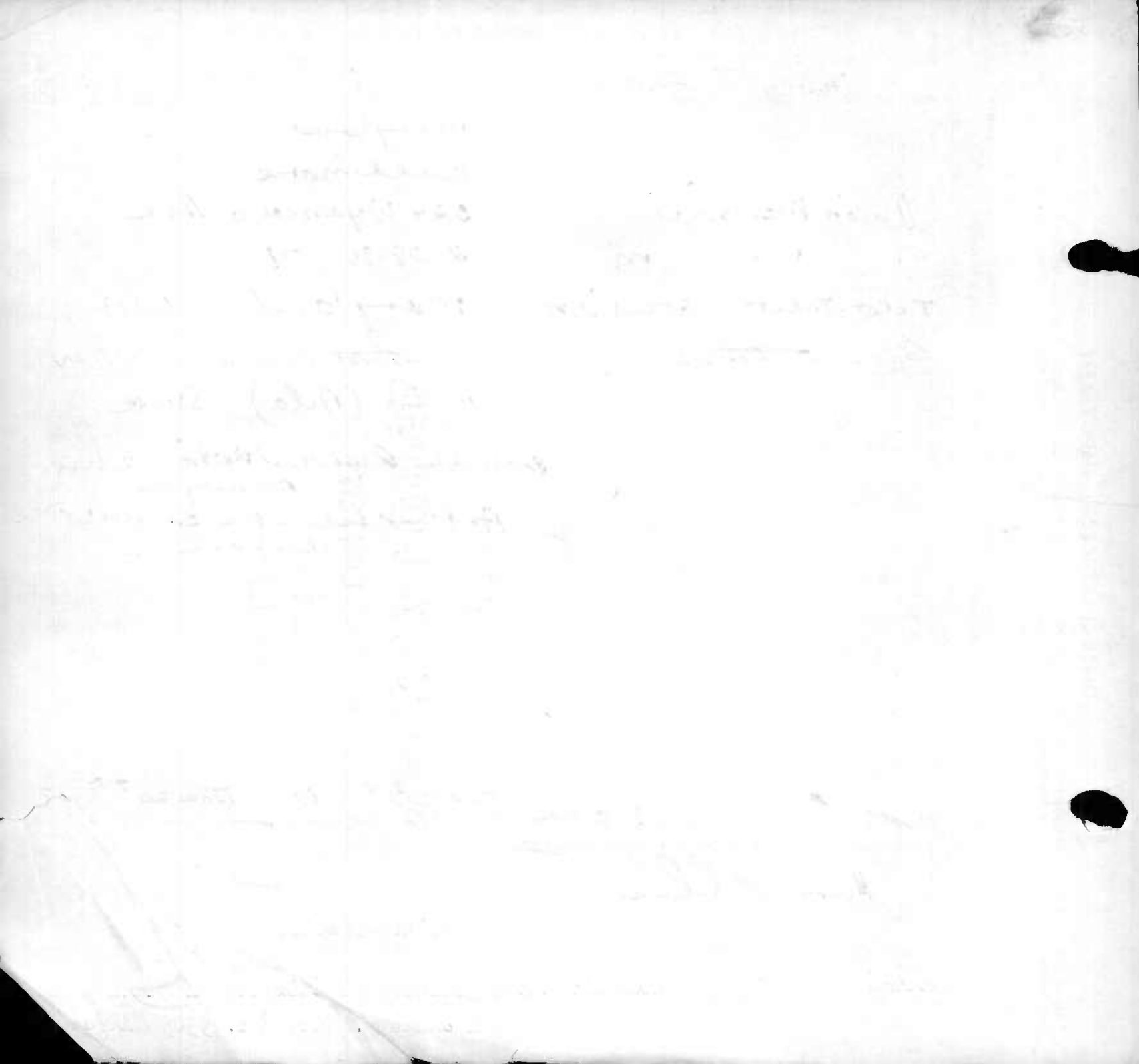
BALTIMORE CITY HEALTH DEPARTMENT				67 6002		Registered No. 67 6002	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				GREEN, ELMER W.		6-20-1967 9 <sup>20</sup> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
49 NORTH CHARLES GEN. HOSP.				MARYLAND		Carroll Co.	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Sykesville		56-00	
				D. STREET ADDRESS (If rural, give location)			
				Rt 1 Box 246 A			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
M	W	WIDOWED	4-7-1895	72			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Mechanic		Balto. Transit Co.		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHARLES GREEN				ELIZABETH HAINES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		215-09-3786		NORTH CHARLES GEN. HOSP. CHART			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
260X I		<p><del>Older disease is generalized</del></p> <p>(A) DUE TO Cerebral Infarct and</p> <p>(B) MYOCARDIAL INFARCTION</p> <p>(C) DUE TO</p> <p>Ba DIABETES MELLITUS</p>					
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 5-30 19 67 to 6-20 19 67.							
that (1) (we) last saw the deceased alive on 6-20 19 67 and that in my (our) opinion death occurred on the day and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
				6-20-1967			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
RANDOLPH SPITZBERG M.D.				6024 Berkeley Ave Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)	
Burial		6/23/1967		Loudon Park Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADD	
JUN 22 1967		Robert E. [Signature]		Wm J. [Signature]		Bc	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6003										BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 6003																																																	
M.E. CASE NO.										1. NAME OF DECEASED (Type or Print) <i>Henry J. Ennis</i>										2. DATE AND HOUR OF DEATH <i>6-20-67 7:35 P.M.</i>																																																	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>																																																	
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial</i>										(If not in hospital or institution, give street address or location)										D. STREET ADDRESS (If rural, give location) <i>624 Wyanoake Ave</i>																																																	
5. SEX <i>m</i>			6. RACE <i>w</i>			7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>m</i>			8. DATE OF BIRTH <i>2-28-96</i>			9. AGE (In years last birthday) <i>71</i>			If Under 1 Yr. Months: Days: Hours: Min.			If Under 24 Hrs. Hours: Min.																																																			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ticket Taker</i>										10B. KIND OF BUSINESS OR INDUSTRY <i>Stadium</i>										11. BIRTHPLACE (State or foreign country) <i>Maryland</i>										12. CITIZEN OF WHAT COUNTRY? <i>USA</i>																																							
13. FATHER'S NAME <i>Silas W. Ennis</i>										14. MOTHER'S MAIDEN NAME <i>Christina Doris Nee Stratten</i>										15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>										16. SOCIAL SECURITY NO.										17. INFORMANT ADDRESS <i>Wife (Ada) Same</i>																													
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>451X I</i>										CAUSE OF DEATH (A) <i>Probable Ruptured Aortic Aneurysm</i> (B) <i>Arteriosclerotic cardiovascular disease</i> (C)										INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>																																																	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED										20A. AUTOPSY? (Yes or No) <i>NO</i>										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)										21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)										21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>										21F. HOW DID INJURY OCCUR?																			
22. I certify that (I) (this hospital) attended the deceased from <i>June 20 7:18</i> 19 <i>67</i> to <i>June 20 7:35</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6-20</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										23A. SIGNATURE <i>Union Memorial</i>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>										23B. DATE SIGNED <i>6-20-67</i>																																							
23C. PHYSICIAN'S NAME (Type)										M.D. <i>Union Memorial</i>										23D. ADDRESS										24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>										24B. DATE <i>6/24/67</i>										24C. NAME of CEMETERY or CREMATORY <i>Lorraine Park Cemetery</i>										24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>									
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 22 1967</i>										25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>										25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>										ADDRESS <i>5305 Harf</i>																																							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6004				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6004			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Mary R. Dennis aka Mary R. Hopkins</b>				2. DATE AND HOUR OF DEATH <b>6/20/1967 2:15</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND								4. USUAL RESIDENCE (If deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland Gen Hospital</b>								A. STATE <b>Maryland</b>			
(If not in hospital or institution, give street address or location)								B. CITY, TOWN, OR VILLAGE (If rural, give township) <b>Baltimore 13-01</b>			
5. SEX <b>Female</b>								6. RACE <b>White</b>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Divorced</b>								8. DATE OF BIRTH <b>9/3/15</b>			
9. AGE (In years, lost births) <b>51</b>								10. If Under 1 Yr. Months: Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>								10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>			
11. BIRTHPLACE (State or foreign country) <b>X Alabama</b>								12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>X Dennis</b>								14. MOTHER'S MAIDEN NAME <b>X Ruby ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)								16. SOCIAL SECURITY NO. <b>219-05-2096</b>			
17. INFORMANT <b>Chart</b>								ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>141.9 I Carcinoma of tongue</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.								(C) DUE TO			
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>NO</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6/20 1967</b> to <b>6/20 1967</b> , that (I) (we) last saw the deceased alive on <b>6/20 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Daniel C. Wilkerson</b>								23B. DATE SIGNED <b>6/20/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>Daniel C. Wilkerson</b>								23D. ADDRESS <b>421 Regester Ave</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>6/22/1967</b>				24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>			
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			
25C. FUNERAL DIRECTOR <b>Wm. J. Zickman &amp; Sons</b>				25D. ADDRESS <b>Baltimore</b>							

I



FUNERAL DIRECTOR: IMPORTANT

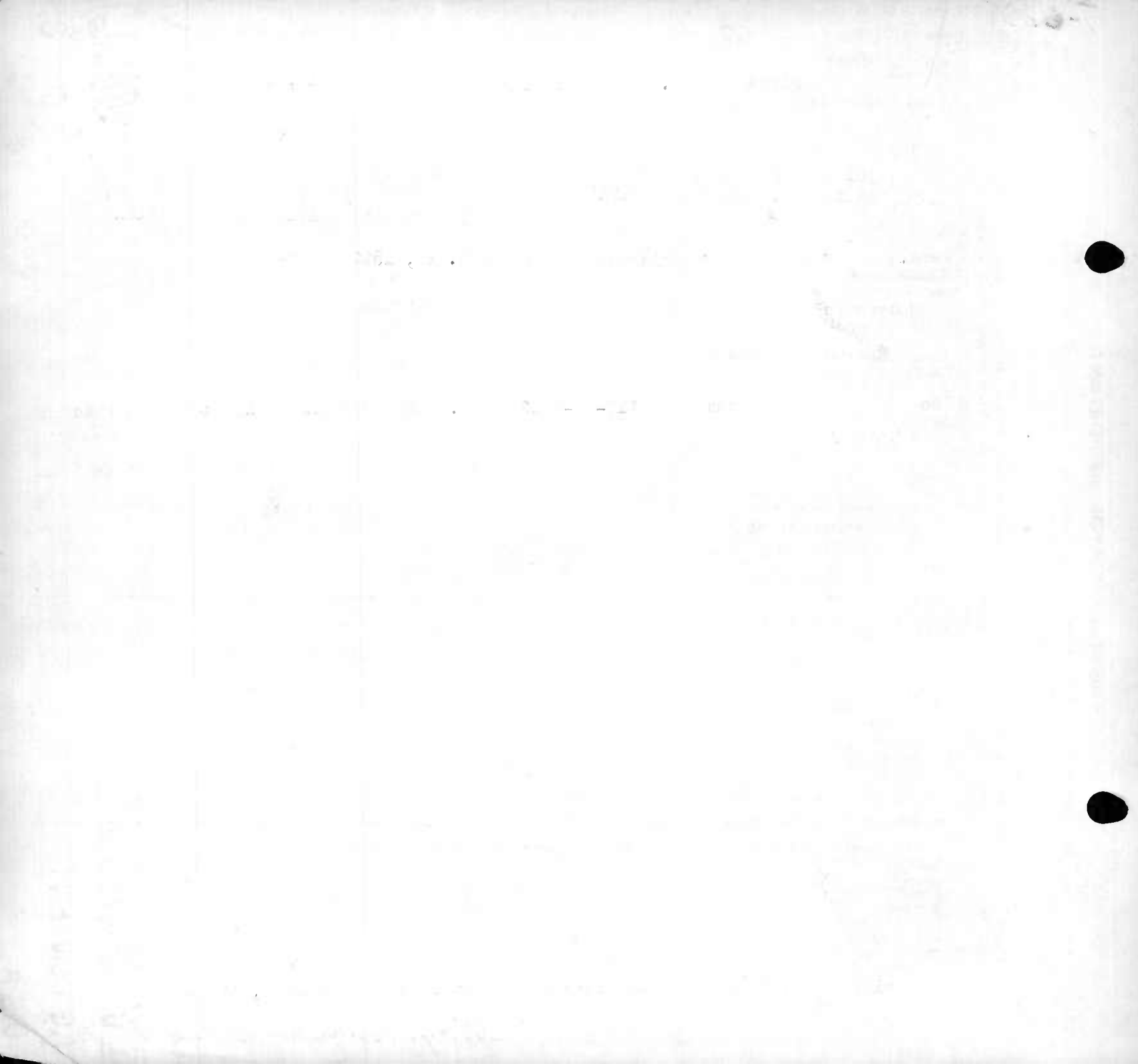
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">67 6005</p> <p style="font-size: 18pt; margin: 0;">Baltimore City Health Department</p> <p style="font-size: 24pt; margin: 0;">67 6005</p>		<p>Registered No. _____</p>	
<p>BIRTH NO. _____</p> <p>M.E. CASE NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) <b>Lillian Catherine Hachtel</b></p>		<p>2. DATE AND HOUR OF DEATH <b>June 20, 1967</b> <span style="float: right;">10 <sup>30</sup> / 18 M.</span></p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>44 Union Memorial Hospital</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b></p>	
<p>5. SEX <b>Female</b></p>		<p>6. RACE <b>White</b></p>	
<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b></p>		<p>8. DATE OF BIRTH <b>April 20, 1899</b></p>	
<p>9. AGE (In years last birthday) <b>66 68</b></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>27-05</b></p>	
<p>13. FATHER'S NAME <b>John Gerhold</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Christina M. Stecher</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. _____</p>	
<p>17. INFORMANT <b>Mr. William Gerhold</b></p>		<p>ADDRESS <b>6530 Walther Avenue</b></p>	
<p>18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b></p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Hypertensive - Cardiovascular Disease</b></p>		<p>CAUSE OF DEATH</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arterio Sclerosis</b></p>		<p>19A. DATE OF OPERATION <b>0</b></p>	
<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> 19<b>56</b> to <b>June 21</b> 19<b>67</b>. that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date _____ and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Wm. J. Byrley</b></p>		<p>23B. DATE SIGNED <b>6/22/67</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>Wm. J. Byrley</b></p>		<p>23D. ADDRESS <b>5420 York Rd Baltimore Md</b></p>	
<p>24A. BURIAL CREMATION, 24B. DATE <b>Burial 6/23/1967</b></p>		<p>24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b></p>	
<p>24D. LOCATION <b>Woodlawn, Md.</b></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b></p>	
<p>25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b></p>		<p>25C. FUNERAL DIRECTOR <b>Wm. J. Byrley &amp; Sons</b></p>	
<p>ADDRESS <b>Baltimore, Md.</b></p>		<p>ADDRESS <b>Baltimore, Md.</b></p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6006		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6006	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Minna K. Taylor			2. DATE AND HOUR OF DEATH June 17, 1967 9 20 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 301 East Highfield Road Baltimore, Maryland 21218			A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 301 East Highfield Road 21210		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Feb. 19, 1892	9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Conrad Knabe			14. MOTHER'S MAIDEN NAME Anna Fleck		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None			16. SOCIAL SECURITY NO. 217-34-8712		17. INFORMANT ADDRESS Mrs. Anne Grasmick 513 Stevenson Lane
18. I 199-2-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) METASTATIC CARCINOMA DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH YEARS
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from on 6/20 1967 to 19 that (I) (we) last saw the deceased alive on 6/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Morton M. Mower M.D.				23B. DATE SIGNED 6/20/67	
23C. PHYSICIAN'S NAME (Type) MORTON M. MOWER M.D.			23D. ADDRESS 200 W. COLDSRING MD. BALTO		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/20/1967		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Mausoleum	
24D. LOCATION Woodlawn, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUN 22 1967		24F. NAME OF REGISTRAR Wm. J. Tucker	
24G. FUNERAL DIRECTOR ADDRESS		24H. DATE		24I. NAME OF REGISTRAR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6007		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 67 6007	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>ERNEST ADOLPH SCHICKLING</b>			2. DATE AND HOUR OF DEATH <b>6/21/67 4:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>36 FRANKLIN SQUARE HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21230</b> D. STREET ADDRESS (If rural, give location) <b>1200 CARROLL ST.</b>		
5. SEX <b>MALE</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SEPARATED MARRIED</b>	B. DATE OF BIRTH <b>1/14/05</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NIGHT WATCHMAN Central Linen Supply</b>			11. BIRTHPLACE (State or foreign country) <b>Ind</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Greet B. Schickling</b>			14. MOTHER'S MAIDEN NAME <b>Martha Glaser</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>218-01-7477</b>		17. INFORMANT ADDRESS <b>CHART HOSPITAL</b>
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>CHRONIC LUNG DISEASE</b>			CAUSE OF DEATH (A) <b>MASSIVE MYOCARDIAL INFARCTION</b> DUE TO (B) _____ DUE TO (C) _____  INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>6/21</b> 19 <b>67</b> to <b>6/21</b> 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>6/21</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ferdinand C. Rodriguez</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/21/67</b>
23C. PHYSICIAN'S NAME (Type) <b>FERDINAND C. RODRIGUEZ</b>			23D. ADDRESS <b>FRANKLIN SQUARE HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/24/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenwood Cem. Washington, D.C.</b>	
24D. LOCATION (City, town, or county) (State) <b>Ind.</b>		25A. DATE REC'D. BY HEALTH DEPT. <b>JUN 22 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>John J. Brown, Sr.</b>		ADDRESS <b>901 Hollins St.</b>	





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6008 CERTIFICATE OF DEATH					Registered No. 67 6008				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>MIRAS. MACHOVEC.</b>					2. DATE AND HOUR OF DEATH <b>6/18/67 1:00 A. M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. OF MD HOSP</b>					A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 26-05</b>				
					D. STREET ADDRESS (If rural, give location) <b>604 TOLNA ST. #21224</b>				
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11/28/26</b>	9. AGE (In years last birthday) <b>40</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>SAMUEL FUNARI (FUNARI)</b>					14. MOTHER'S MAIDEN NAME <b>A DELE FILESI</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>215-22-1091</b>		17. INFORMANT <b>JOSEPH J. MACHOVEC</b>		ADDRESS <b>SAME</b>		
18. <b>201X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. If means the disease, injury or complication which caused death.) <b>CRYPTOCOCCAL MENINGITIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>MOS</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HODGKINS DIS</b>					<b>&gt; 10 YRS</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>6/16/67</b> 19 to <b>6/18/67</b> 19 that (I) (we) last saw the deceased alive on <b>6/18/67</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>H. Louden K. Krueger</b> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/18/67</b>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-22-67</b>		24C. NAME of CEMETERY or CREMATORY <b>SACRED HEART CEM</b>		24D. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD. BALTO. CO., MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Charles J. [Signature]</b> ADDRESS <b>6224 EASTERN AVE. BALTO., 21224, MD.</b>					



67 6009

BALTIMORE CITY HEALTH DEPARTMENT

67 6009

BIRTH NO. 67-06340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WANDA

JASPER

2. DATE AND HOUR PRONOUNCED DEAD

5-27-67

6:25 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1316 N. Fremont Avenue

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
lost birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

7 weeks

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Interstitial pneumonitis - (SDII)  
DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-27-67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

CREMATED

23B. DATE

6-12-67

23C. NAME OF CEMETERY or CREMATORY

MEDICAL EXAMINERS

23D. LOCATION

(City, town, or county)

(State)

BALTO.

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 22 1967

Robert E. Fisher, M.D.

MORGA E

WALLACE FORGIE

67 6010

BALTIMORE CITY HEALTH DEPARTMENT

67 6010

BIRTH NO. 67-5147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print)		VALERIE JOHNSON		2. DATE AND HOUR PRONOUNCED DEAD 4-3-67 9:40 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL - DOA		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 18-01 D. STREET ADDRESS (If rural, give location) 928 W. Fayette Street			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) 3 wks	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) INTERSTITIAL PNEUMONITIS - (SDII) (A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		WERNER U. SPITZ, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23D. LOCATION (City, town, or county) (State)	
CREMATED		5-2-67		MEDICAL EXAMINERS BALTO. MD.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JUN 22 1967		Robert E. Farley, M.D.		MORGENF	





67 6011

BIRTH NO. 67-13619 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
GLADYS FERGUSON		6-2-67 6:30 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
JOHNS HOPKINS HOSPITAL - DOA		Maryland	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		1218 E. Madison Street 21202	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Female	Colored		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO	
INTERSTITIAL PNEUMONITIS - (SDII)			
ANTECEDENT CAUSES		(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
			Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
			Yes
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
RUSSELL S. FISHER, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED		6-2-67	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	23C. NAME OF CEMETERY OR CREMATORY
CREMATED		6-12-67	MEDICAL EXAMINERS BALTO. MD.
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
JUN 22 1967		Robert E. Fisher	MORQUE

WALKLEY BOOKS

BOOKS AND PAPERS

Remounted from the original

67 6012

BALTIMORE CITY HEALTH DEPARTMENT

67 6012

BIRTH NO.

67-12652

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

UNKNOWN BABY GIRL

2. DATE AND HOUR PRONOUNCED DEAD

February 21, 1967 5:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Found  
2300  
2400 Block of Hollins Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE UNKNOWN

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

UNKNOWN

D. STREET ADDRESS (If rural, give location)

UNKNOWN

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

-NEWBORN-

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

30

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoma, etc. It means the disease,  
injury or complication which caused death.)(A) Strangulation by ligature  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.) UNKNOWN21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

UNKNOWN

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

UNKNOWN

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Was Apparently Strangled.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2/22/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremated

23B. DATE

3-22-67

23C. NAME of CEMETERY or CREMATORY

Medical Examiner's Office

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 22 1967

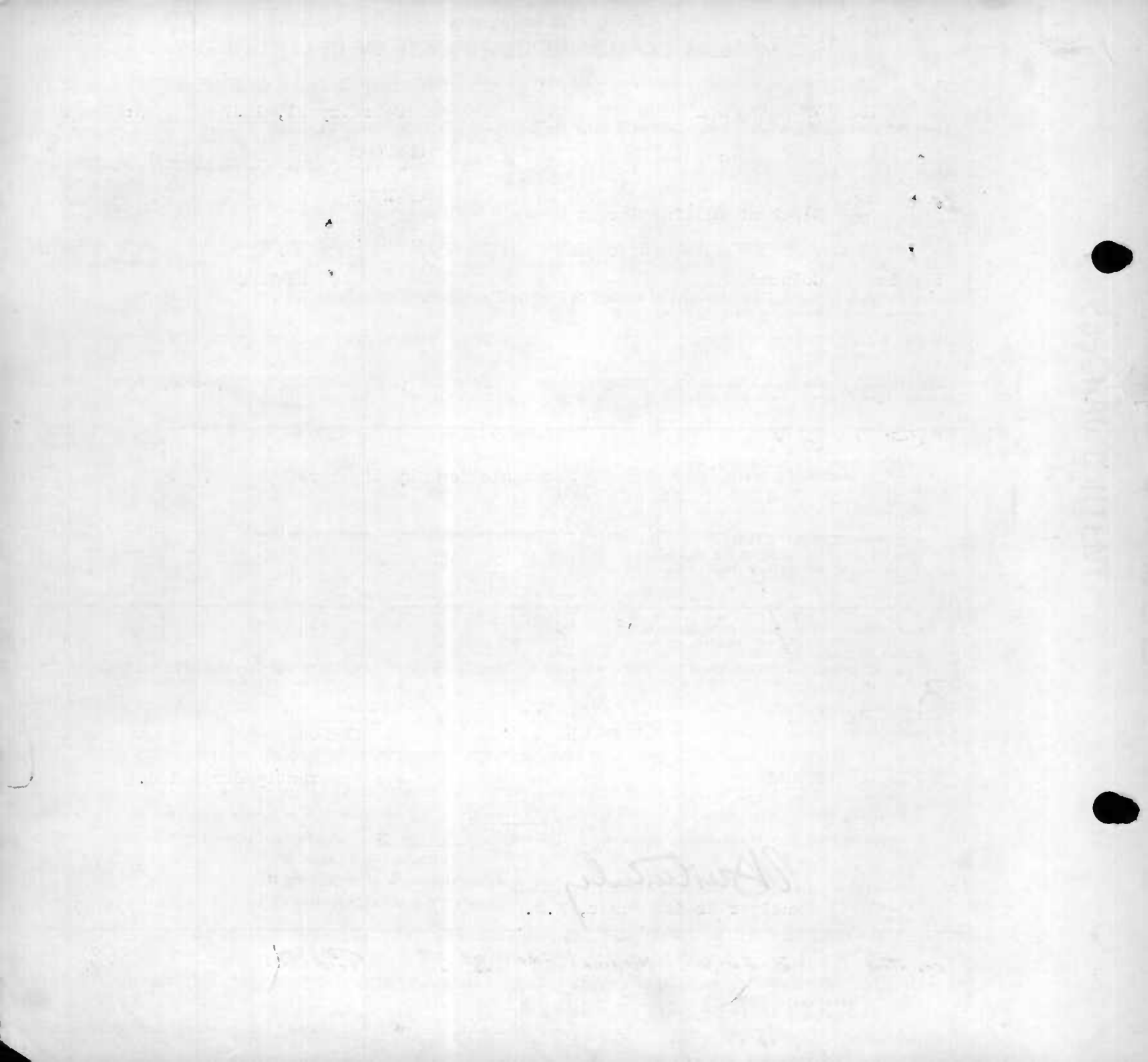
24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

MORRIS

ADDRESS



## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. **67 6013** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 6013**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIE ADAMS</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>June 20, 1967 3:25 p. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>2931 Riggs Avenue</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2931 Riggs Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>12/31/1889</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>77</b>
13. FATHER'S NAME <b>Richmond Adams</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
16. SOCIAL SECURITY NO. <b>242-20-6050</b>		14. MOTHER'S MAIDEN NAME <b>Katie Johnson</b>	
17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bronchogenic Carcinoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>6/21/67</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>6/24/67</b>	
23C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		23D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
24C. FUNERAL DIRECTOR <b>C. Wainwright</b>		ADDRESS <b>2700 Edmondson A</b>	

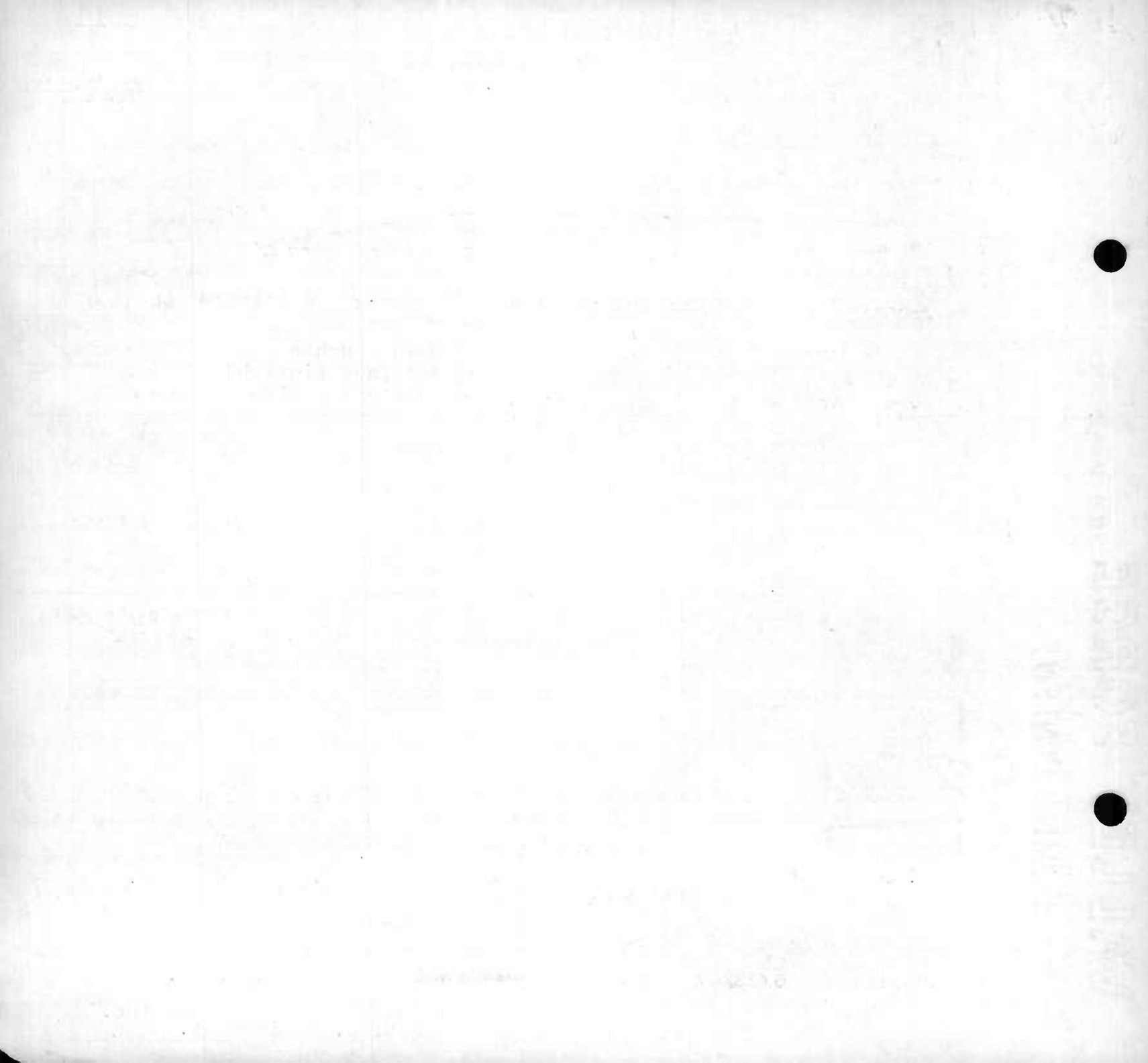




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6014		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6014	
M.E. CASE NO.		(Also known as)		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Elmer E. Mace		Edward E. Murphy		June 20, 1967 4:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital			A. STATE B. COUNTY Maryland Baltimore		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 602		
D. STREET ADDRESS (If rural, give location) 425 N. Belmond Ave					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 5/1/93	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Carpenters Union		11. BIRTHPLACE (State or foreign country) Maryland Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Elmer Mace		14. MOTHER'S MAIDEN NAME Mary Mehan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes Army WW I		16. SOCIAL SECURITY NO. 212-18-2054		17. INFORMANT (nee Pietsch) Frona Mace wife same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO Cerebrovascular Insuff. (B) DUE TO ASCLVD (C) _____		INTERVAL BETWEEN ONSET AND DEATH weeks years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Severe emphysema; mod. cirrhosis, chronic pyelonephritis, azotemia		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1, 1967 to June 20, 1967, that (I) (we) lost saw the deceased alive on June 20, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Michael Gould		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/20/67	
23C. PHYSICIAN'S NAME (Type) W. MICHAEL GOULD		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/23/67		24C. NAME of CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 22 1967		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St.		25D. ADDRESS			



48-63-107-4160  
VLB

67 6015

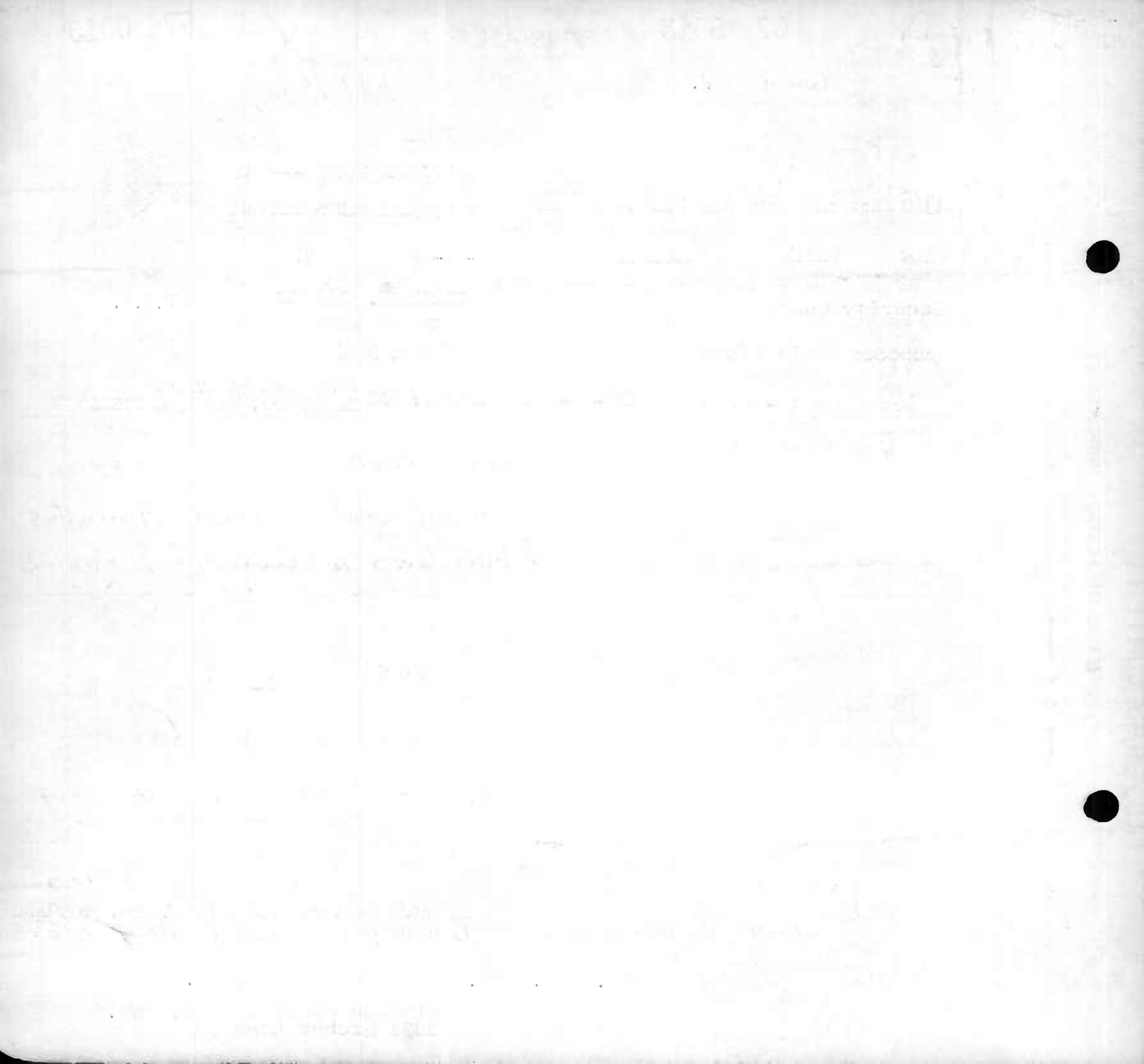
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 6015

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				GORDON W. TYLER		6/16/67 11:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
BALTIMORE CITY Hosp. 21224 4940 Eastern Avenue Baltimore, Maryland				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE 21222 --- 005			
				D. STREET ADDRESS (If rural, give location)			
				2801 GRAY MANOR TERRACE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days Hours Min.	
MALE	WHITE	MARRIED		5-11-96	71		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Security Guard				MARYLAND, CHANCE		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
EDWIN TYLER				JONES, MARY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
yes WW 1 - Army		216-05-8544		Records: BCH 4940 Eastern Avenue Baltimore, Maryland 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				g.i. bleed		1 hr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO esophageal varices		9 months	
				(C) Metastases in liver.		9 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/12/67 1967 to 6/16 1967, that (I) (we) last saw the deceased alive on 6/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John C. Whelton M.D.				6/16/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOHN C. WHELTON M.D.				4940 Eastern Avenue Baltimore, Maryland BALTIMORE CITY HOSPITAL 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/20/67		Balto. Nat. Cem.		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 22 1967		Robert E. Taylor		Schimunek Funeral Home, Inc. 3331 Brehms Lane			


FUNERAL DIRECTOR: IMPORTANT

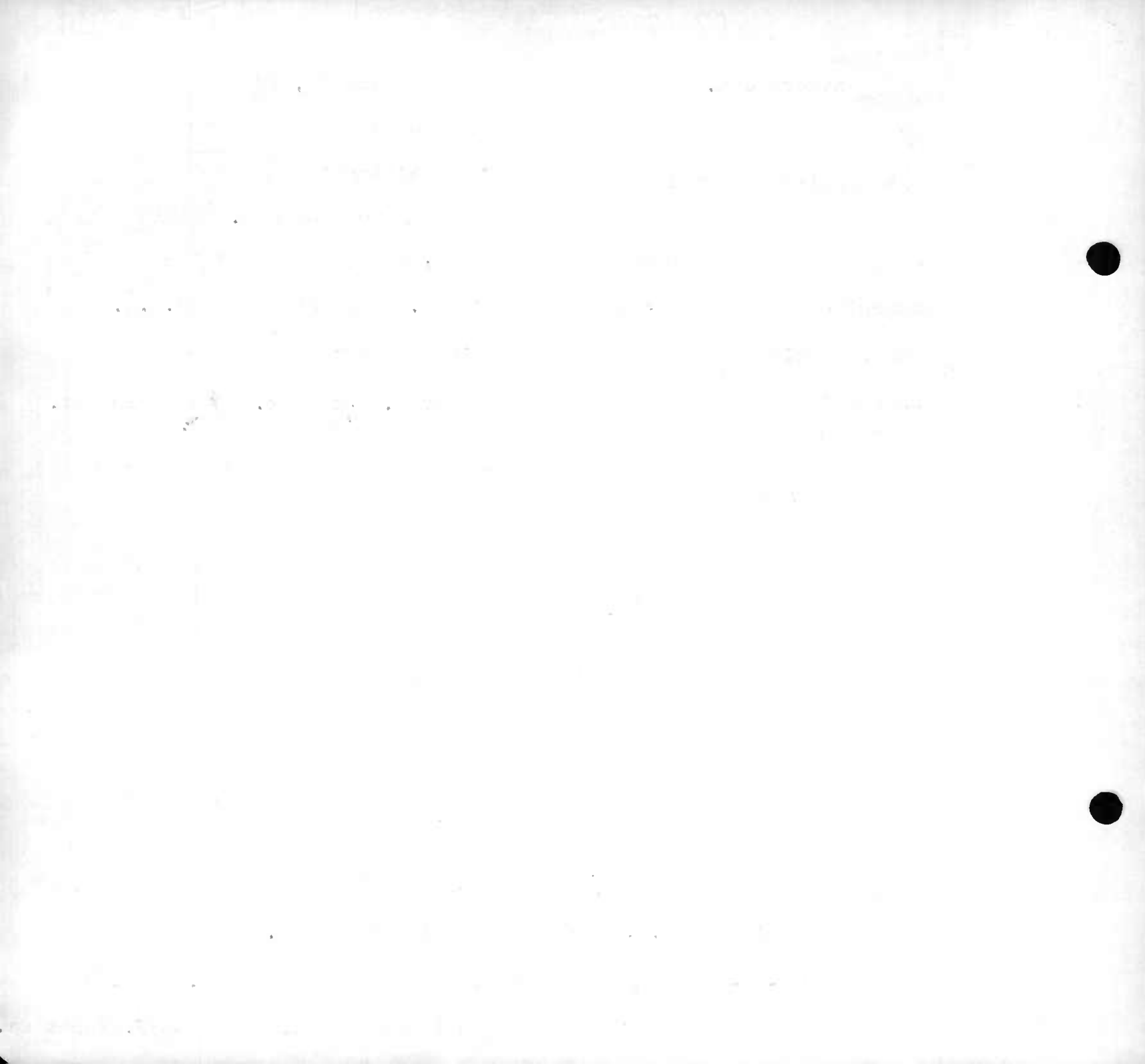
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6016</b>	
BIRTH NO. <b>67 6016</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Catherine E. Burns</b>		2. DATE AND HOUR OF DEATH <b>June 16, 1967</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3342 Ravenwood Ave. 21213</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan 1, 1888</b>	9. AGE (In years lost birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Andrew Fritz</b>		14. MOTHER'S MAIDEN NAME <b>Anna Wagner</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Thomas E. Burns Jr. 7005 Conley St.</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>Acute coronary thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <b>Acute coronary thrombosis</b> DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/13/62</b> to <b>6/14/67</b> 19... that (I) (we) last saw the deceased alive on <b>6/16/67</b> 19... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D. <b>Marion Friedman M.D.</b>				23B. DATE SIGNED <b>6/19/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Marion Friedman M.D.</b>				23D. ADDRESS <b>5211 Harford Rd.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-20-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home 3335 Brehms La.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6017</b>	
BIRTH NO. <b>67 6017</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>AGNES M. HORKY</b>		2. DATE AND HOUR OF DEATH <b>June 18, 1967 10 a.</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION  <b>803 N. Port St. Baltimore, Md. 21205</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>803 N. Port St.</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>1/2/96</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Char-lady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Anton Dobihal</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Ella Horky, dght, 803 N. Port St.</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Hypertens. C.V.D.s.</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>DEC. 1965</b> to <b>6-18 1967</b> , that (I) <del>was</del> lost saw the deceased alive on <b>6-17-1967</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <b>did</b> (did not) view the body after death.					
23A. SIGNATURE <b>Benjamin Moses</b> M.D.				23B. DATE SIGNED <b>6-20-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Benjamin Moses</b> M.D.				23D. ADDRESS <b>448 N. Luzerne Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/21/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Bohemian Nat. Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 2601 E. Madison St.</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6018</b>	
BIRTH NO. <b>67 6018</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>GOLANER, Margaret W.</b>		2. DATE AND HOUR OF DEATH <b>June 18, 1967 3:30 a.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3208 Kentucky Ave. Baltimore, Md. 21213</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>26-03</b> D. STREET ADDRESS (If rural, give location) <b>3208 Kentucky Ave.</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>9/13/05</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Tel. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Charles Wise</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-18-3244</b>		17. INFORMANT ADDRESS <b>Sylvan Golaner, husband, above</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Chronic nephritis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive C.V.D.</b>		CAUSE OF DEATH (A) <b>Chronic nephritis</b> DUE TO (B) <b>Hypertensive C.V.D.</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>10 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1953</b> to <b>June 1967</b> , that (I) (we) last saw the deceased alive on <b>6-17 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Duer Moores</b>				23B. DATE SIGNED <b>6-18-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. J. Duer Moores</b>		23D. ADDRESS <b>3105 Belair Road</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/21/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Schimunek</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-20-901N		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6019	
BIRTH NO. 67 6019		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Dobry, Frances M.</b>		2. DATE AND HOUR OF DEATH <b>6/14/67 1:30 a. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		7-03	
D. STREET ADDRESS (If rural, give location) <b>2104 E. JEFFERSON STREET 21205</b>					
5. SEX <b>Female</b> <del>MALE</del>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>4-1-92</b>	9. AGE (In years lost birthday) <b>75</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>FRANK C. HUDECEK</b>		14. MOTHER'S MAIDEN NAME <del>XXXXXXXX</del> <b>Anna Zaharanska</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-07-0864</b>		17. INFORMANT <b>and Mrs. Leoba Andrezejewski</b> <b>BCH: RECORDS 4940 EASTERN AVENUE 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Adenocarcinoma of colon</b> <b>metastatic Ca. of Liver.</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>chronic C. I. bleeding</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White A <input type="checkbox"/> Not White A <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that <del>(H)</del> (this hospital) attended the deceased from <b>May 9 1967</b> to <b>June 18 1967</b> , that <del>(H)</del> (we) last saw the deceased alive on <b>June 18 1967</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(H)</del> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Carl Winterstein</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/18/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. CARL WINTERSTEIN</b>		M.D.		23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE BALTO. MD. 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/22/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Schimunek</b>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>2601 E. Madison St.</b>		ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6020	
BIRTH NO. 67 6020		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>HILDA L. AMRHEIN</u>		2. DATE AND HOUR OF DEATH <u>JUNE 18, 1967</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BALTO. CITY HOSP</u>		A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>ESSEX</u>			
		D. STREET ADDRESS (If rural, give location) <u>624 DORSEY AVE</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCT 6, 1910</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HARRY S. BATES</u>		14. MOTHER'S MAIDEN NAME <u>MARY HAMMER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-44-0110</u>		17. INFORMANT <u>MARY DE PETRO</u>	
18. <u>420.11551.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic CVD myocardial infarction</u>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>ABOVE</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hepatitis Alcoholic Toxicity</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 1967</u> to <u>June 1967</u> , that (I) <u>last</u> saw the deceased alive on <u>June 8, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>did not</u> view the body after death.					
23A. SIGNATURE <u>William L. Tyson</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6-20-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>William L. Tyson</u>		23D. ADDRESS <u>Kingsville Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/22/67</u>		24C. NAME of CEMETERY or CREMATORY <u>HOLY REDEEMER</u>	
24D. LOCATION <u>BALTO. MD.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUN 22 1967</u>			
25A. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25B. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u>		ADDRESS <u>300 MACE</u>	

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 6021

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JENNIE SUDBRINK

2. DATE AND HOUR OF DEATH

6-20-67

10:59 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Ave.  
Baltimore, Maryland # 212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore - Dundalk

D. STREET ADDRESS (If rural, give location)

125 Bayside Drive 21222 005

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Widowed

8. DATE OF BIRTH

6-28-89

9. AGE (In years  
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

? Bertrand

14. MOTHER'S MAIDEN NAME

Not Known

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
820-00-7970

17. INFORMANT

ADDRESS

BCH: Records 4940 Eastern Ave. Baltimore, Md. #21224

18. 260X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Myocardial Infarction

3 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) DUE TO

ISCVD

years

(C) DUE TO

Diabetes Mellitus

years

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(did not)~~ attended the deceased from 6-6 19 67 to 6-20 19 67  
that (I) ~~(did not)~~ lost saw the deceased alive on 6/20 19 67 and that in (my) ~~(low)~~ opinion death occurred on the date  
and hour and from the causes stated above. (I) ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE

David J. Mischelevich

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

6-20-67

23C. PHYSICIAN'S  
NAME (Type)

David J. Mischelevich

M.D.

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Ave. Baltimore, Maryland #2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

6/23/67

24C. NAME OF CEMETERY or CREMATORY

Bel Air Memorial Gardens Cem.

24D. LOCATION

(City, town, or county) (State)

Bel Air, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUN 22 1967

25B. NAME OF REGISTRAR

John J. Duda

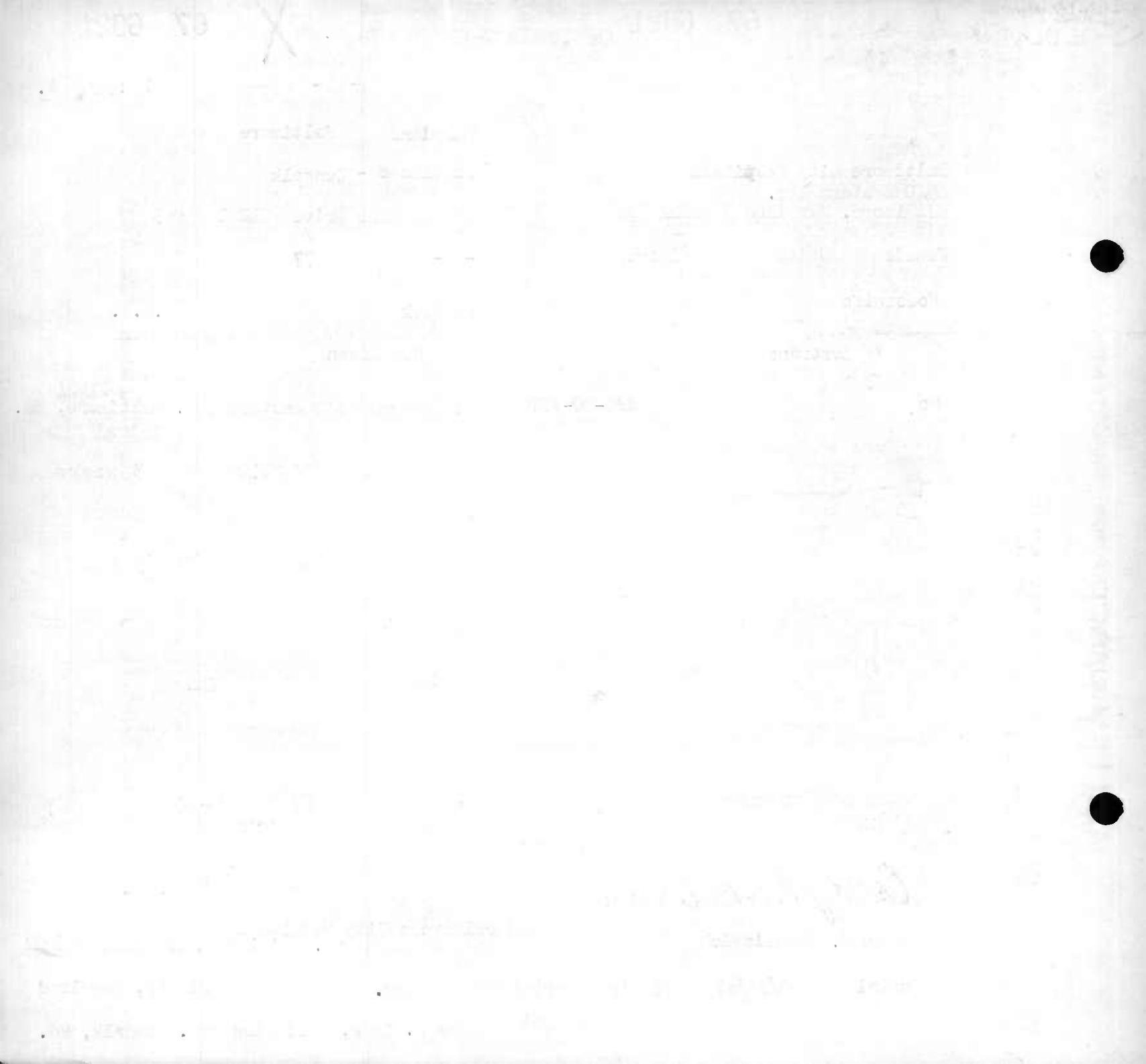
25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

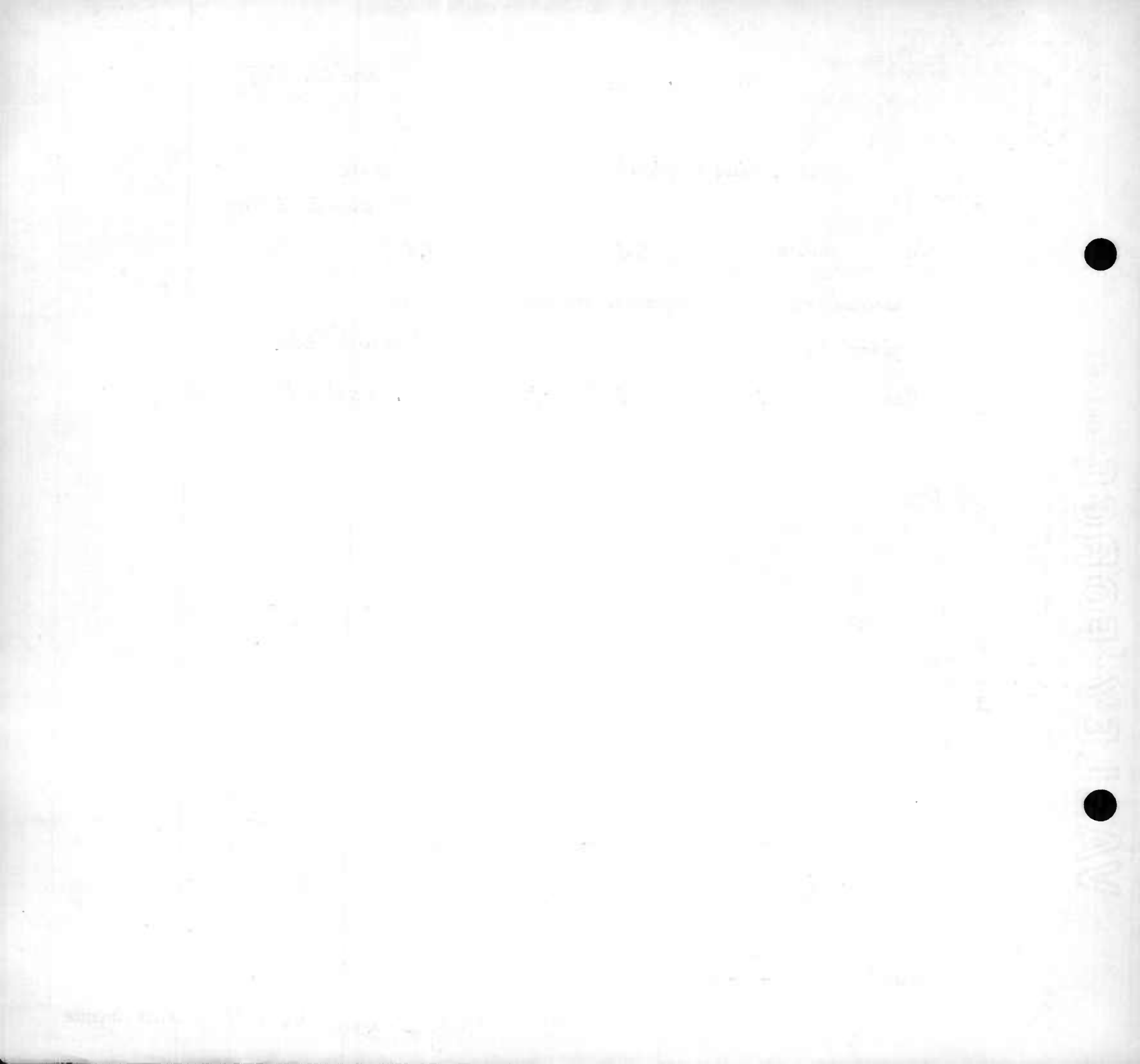




# FUNERAL DIRECTOR: IMPORTANT

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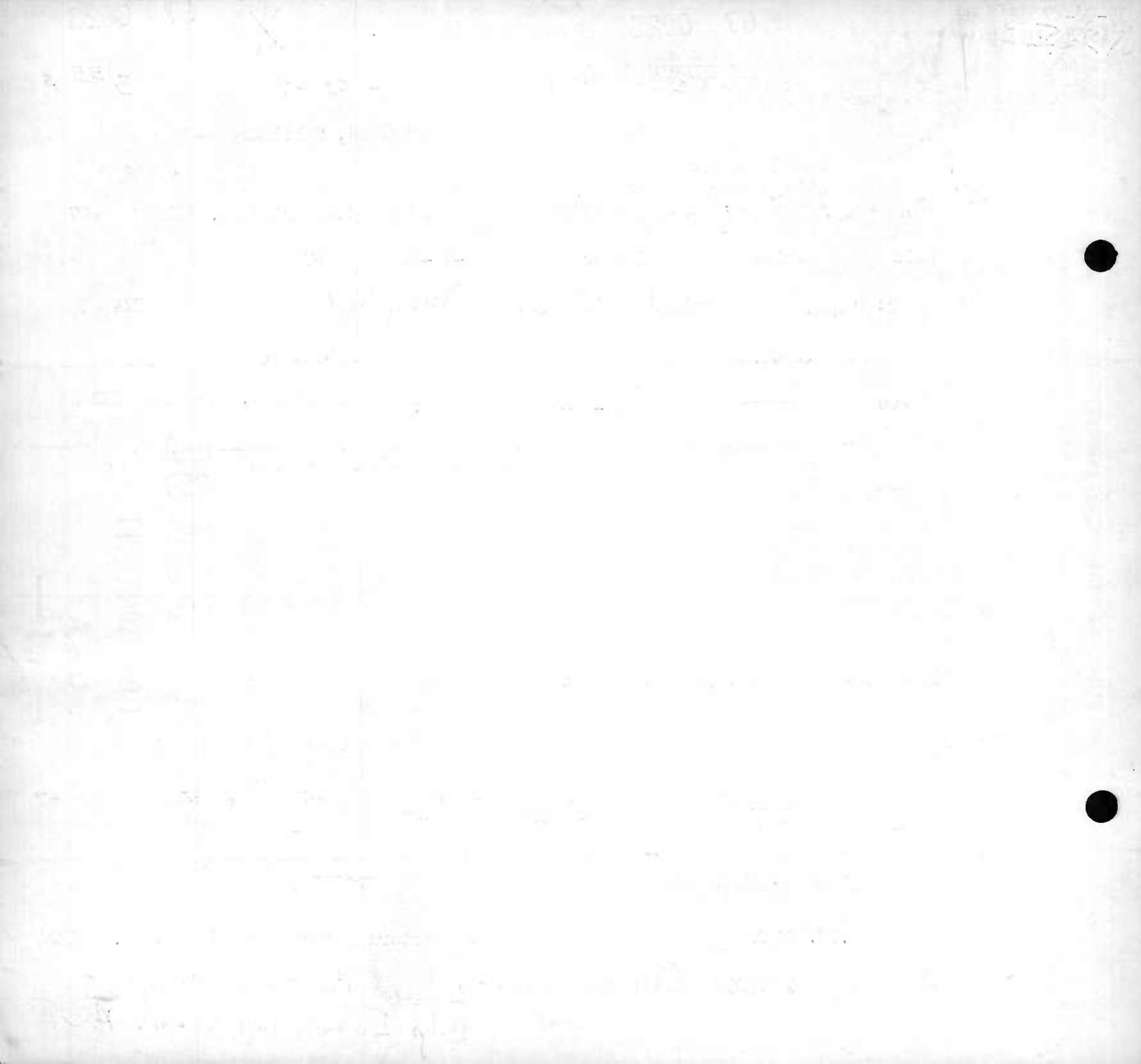
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6022		67 6022		67 6022	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MARTIN F. APPEL			June 20, 1967 6:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Johns Hopkins Hospital			Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			2718 Pulaski Highway		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Married	July 1, 1895	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Assemblyman		Edgewood Arsenal		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Edward Appel			Elizabeth Fisher		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		215 09 0474 T		Marie M. Appel 2718 Pulaski Highway	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) cardio-renal-vascular disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) DUE TO		
19A. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 19 1967 to June 20 1967, that (I) (we) last saw the deceased alive on June 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
L. C. Dobihal			6/20/67		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
L. C. Dobihal			4474 Kenwood Ave. Baltimore Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	6-23-67	Baltimore National Cemetery	Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
JUN 22 1967	Robert E. Tanaka	R. J. F. Quail 1211 Chesaco Avenue			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6023				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6023					
M.E. CASE NO. 1. NAME OF DECEASED								2. DATE AND HOUR OF DEATH					
(Type or Print) <i>Raymond E. Rosenthal</i>								6-20-67 3:30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>BALTIMORE CITY HOSPITALS</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland #21224</i> <i>Baltimore City Hospitals</i>								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland, Baltimore</i> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township)  D. STREET ADDRESS (If rural, give location) <i>Box 398 Coldspring Rd. #21220 007</i>					
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widower</i>		8. DATE OF BIRTH <i>5-25-00</i>		9. AGE (In years lost birthday) <i>67</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stillman</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Standard Oil Co.</i>				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Unknown</i>								14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>no</i>				16. SOCIAL SECURITY NO. <i>215-05-8806</i>		17. INFORMANT <i>BCH 4940 Eastern Avenue</i> <i>Baltimore, Maryland #21224</i>							
18. <i>143X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								CAUSE OF DEATH (A) <i>Carcinoma floor of mouth</i> DUE TO (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <i>~ 1 yr</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.													
19A. DATE OF OPERATION <i>01-11-66</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca floor of mouth</i>				20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>6-4</i> 19 <i>67</i> to <i>6-20</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6-20</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <i>A. J. Gill</i>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-20-67</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. <i>4940 Eastern Avenue Baltimore, Md. #21224</i>									
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE <i>6/23/67</i>				24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>					
24D. LOCATION <i>Baltimore, Maryland</i>				24E. DATE REC'D BY HEALTH DEPT. <i>JUN 22 1967</i>				24F. NAME OF REGISTRAR <i>Robert E. ...</i>					
24G. FUNERAL DIRECTOR <i>Philip E. ...</i>				24H. ADDRESS <i>1211 Chesapeake Ave.</i>									



1  
M 2 63

67 6024

BALTIMORE CITY HEALTH DEPARTMENT

67 6024

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

EILEEN

A. J.

McGRATH

2. DATE AND HOUR PRONOUNCED DEAD

June 18, 1967

7:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL ( DOA)

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2921 Montebello Terrace

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 10, 1933

9. AGE (In years last birthday)

34

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Dental Ass't.

10B. KIND OF BUSINESS OR INDUSTRY

Dentist

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Carl Marsh

14. MOTHER'S MAIDEN NAME

Grace Wingard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-30-3736

17. INFORMANT

ADDRESS

John W. McGrath-2921 Montebello Ter.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia due to obstruction of airway by foreign body (partial artificial denture)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2921 Montebello Terrace

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

June 18, '67 6:45 p.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject swallowed teeth

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion

resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/19/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Removal

23B. DATE

6/23/67

23C. NAME OF CEMETERY or CREMATORY

Richland Cemetery

23D. LOCATION (City, town, or county) (State)

Johnstown, Penna.

24A. DATE REC'D BY HEALTH DEPT.

JUN 22 1967

24B. NAME OF REGISTRAR

Robert E. Spitz

24C. FUNERAL DIRECTOR

Robert C. Altenburg-6009 Harford Rd. Funeral Home, Inc.

ADDRESS

N 99 11 9 6 7 0 0 0 6 0 3 4

2-10-52

WALKER POLICE

WALKER POLICE

WALKER POLICE

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6025</b>
BIRTH NO. <b>67 6025</b>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPH WASKINS</b>		2. DATE AND HOUR OF DEATH <b>6/17/67</b> <b>6<sup>30</sup> A.M.</b>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL OF BALTIMORE</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3601 PINKNEY RD. #15</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>12/25/99</b>	9. AGE (In years last birthday) <b>67</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RELIABLE STORES</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>EXECUTIVE</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>
13. FATHER'S NAME <b>HYMAN WASKINS</b>		14. MOTHER'S MAIDEN NAME <b>BERTHA LEVITT</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>214-61-4844</b>		17. INFORMANT <b>HOSPITAL CHART</b>
18. <b>4-20-1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 da.</b>  <b>12 YEARS</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>PULMONARY EMBOLI</b>				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>5/19</b> 19 <b>67</b> to <b>6/17</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/17</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Sheldon Frank</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/17/67</b>
23C. PHYSICIAN'S NAME (Type) <b>SHELDON FRANK</b>		23D. ADDRESS M.D. <b>SINAI HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>6/19/67</b>	24C. NAME of CEMETERY or CREMATORY <b>HEBREW FRIENDSHIP</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., INC., 6010 REIST., RD.</b>





**FUNERAL DIRECTOR: IMPORTANT**

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BIRTH NO. 67 6026				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6026	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>MINNIE SANDLER</b>			
2. DATE AND HOUR OF DEATH <b>JUNE 17, 1967 4:20 P. M.</b>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3705 CLARKS LANE</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>27-20</b> D. STREET ADDRESS (If rural, give location) <b>3705 CLARKS LANE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>77</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>ISRAEL ZIEV</b>				
14. MOTHER'S MAIDEN NAME <b>BESSIE ?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				
16. SOCIAL SECURITY NO. <b>NO</b>			17. INFORMANT <b>MR. GILBERT SANDLER, 6104 WESTCLIFF DR. #9</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Aneurysm</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Arteriosclerosis +</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>20 yrs</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 17, 1967</b> to <b>June 17, 1967</b> and that (I) (we) last saw the deceased alive on <b>June 17, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Joseph B Gross</b> M.D.				23B. DATE SIGNED <b>June 17, 1967</b>			
23C. PHYSICIAN'S NAME (Type) <b>Joseph B Gross</b> M.D.				23D. ADDRESS <b>6911 Park Heights Ave.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/19/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>(ANSHE EMUNAH) - AITZ CHAIM</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>			



67 6027

BALTIMORE CITY HEALTH DEPARTMENT

67 6027

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)ROSE  
~~XXXXXXXXXX~~ STEINBERG

2. DATE AND HOUR PRONOUNCED DEAD

June 17, 1967 1:52 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1303 North Calvert Street

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

NOVEMBER, 1926

9. AGE (in years  
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.  
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

HARRY NUSENKO

14. MOTHER'S MAIDEN NAME

DORA BONDROFF

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

UNKNOWN

17. INFORMANT

ADDRESS

Mr. JEROME NUSENKO, 6744 TOWNBROOK DRIVE, APT #7

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Acute intoxication by barbiturate  
and ethanol

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1303 North Calvert Street

21D. TIME OF INJURY (APPROX.)  
(Month) (Day) (Year) (Hour)  
Between 6 pm 6-16-67  
and 1 am 6-17-67

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Took overdose of barbiturate

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 17, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

6/19/67

23C. NAME of CEMETERY or CREMATORY

OHEB SHALOM

23D. LOCATION

(City, town, or county)

BALTIMORE, MARYLAND

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 22 1967

24B. NAME OF REGISTRAR

Robert E. Fisk

24C. FUNERAL DIRECTOR

SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.

ADDRESS

WALLACE PRODUCTIONS  
A WALLACE PAPER  
Company

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

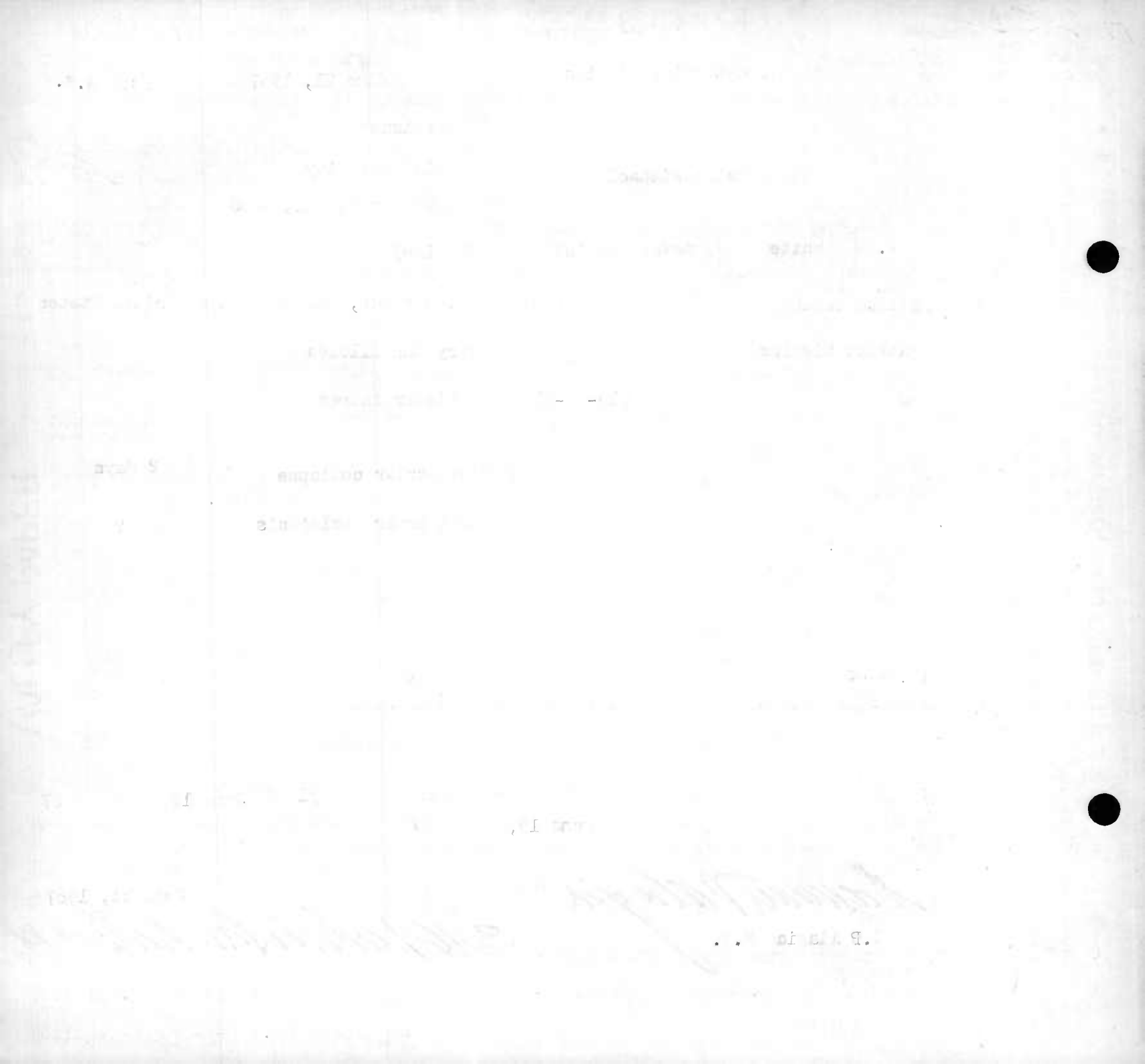
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6028	
BIRTH NO. 67 6028		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MAX GREENBAUM</u>		2. DATE AND HOUR OF DEATH <u>JUNE 18, 1967</u> <u>1:05</u> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL</u>		D. STREET ADDRESS (If rural, give location) <u>4008 GROVELAND AVENUE</u>		28-41	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1897</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HIRSCH GREENBAUM</u>		14. MOTHER'S MAIDEN NAME <u>IDA ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-30-9911A</u>		17. INFORMANT <u>MRS. KATE GREENBAUM, 4008 GROVELAND AVE.</u>	
18. <u>163X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>Carcinoma of Lungs</u> DUE TO (B) <u>generalized metastasis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> <u>1967</u> to <u>6/15</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>6/15</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Israel Zinberg</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6/19/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. ISRAEL ZINBERG</u>		23D. ADDRESS <u>4000 W. NORTHERN PARKWAY</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/19/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>CHEVRA AHAVAS CHESED</u>	
24D. LOCATION <u>RANDALLSTOWN, MARYLAND</u>		24E. STATE <u>MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 22 1967</u>		25B. NAME OF REGISTRAR <u>Dr. E. E. Fisher</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 6029					Registered No. 67 6029					
CERTIFICATE OF DEATH										
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
					Sister Catherine Higgins			June 21, 1967 5:50 A.M. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION  Villa Saint Michael					A. STATE Maryland B. COUNTY Baltimore City					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
					D. STREET ADDRESS (If rural, give location)					
					4000 Forest Hill Road					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
F.	White	never married		7/30/1883	83					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Retired teacher			Sister of Charity		Leominster, Massachusetts			United States		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME						
Patrick Higgins				Mary Ann Illelea						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No				213-50-2189		Sister Andrea				
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>Cardiovascular collapse</u> DUE TO (B) <u>General arteriosclerosis</u> DUE TO (C) _____					
					INTERVAL BETWEEN ONSET AND DEATH  <u>2 days</u>  <u>?</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
None						None				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>September 19 31</u> to <u>June 19, 19 67</u> , that (I) (we) last saw the deceased alive on <u>June 19, 19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED		
<u>D.P. Alagia</u>								June 21, 1967		
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS				
D.P. Alagia M.D.						3376 J. Edgar Hoover Bldg 29 18				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
burial			June-23-67		Seton		6420 Reisterstown Rd. 21215			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS				
JUN 22 1967			Robert E. Taylor			Stewart & Mowen Co. 108-W-North-Av 21201				





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6030				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 6030	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>HARRISON, WILLIAM D.</b>		2. DATE AND HOUR OF DEATH <b>6/20/67</b>		<b>1:45 PM.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>LUTHERAN HOSPITAL OF MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>AG</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>8203 HOLLY ROAD</b>	
5. SEX <b>M</b>				6. RACE <b>W</b>		7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>7-20-06</b>	
9. AGE (In years last birthday) <b>60</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BALTIMORE TRANSIT CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Harrison</b>				14. MOTHER'S MAIDEN NAME <b>Barbara-Six-- Mary Six</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>BARBARA</b>		ADDRESS <b>8203 HOLLY RD.</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA OF PANCREAS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				19. DATE OF OPERATION <b>6/1/67</b>		20. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6/16/1967</b> to <b>6/20/1967</b> , that (I) (we) last saw the deceased alive on <b>6/20/1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.				23A. SIGNATURE <b>V. Biswanath Pillai</b>		23B. DATE SIGNED <b>6/20/67</b>		23C. PHYSICIAN'S NAME (Type) <b>Y. BISWANATH PILLAI</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>6/23/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Olivet Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>				25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>McCully F H</b>		ADDRESS <b>237 Patapsco Ave 21225</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67. 6031		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67. 6031	
I.D.E. CASE NO.		NAME OF DECEASED (Type or Print) METCALF, VIOLET		2. DATE AND HOUR OF DEATH 6/19/67 11:5 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 34	
5. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		6. DATE OF BIRTH 11-30-1897		9. AGE (In years lost birthday) 67 69	
7. SEX Female		8. RACE White		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JAMES DALE- GALE	
14. MOTHER'S MAIDEN NAME CARRIE DAHN- Dahl		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-1096	
17. INFORMANT ADDRESS		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Emboli and Myocardial Infarction Illofemoral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. DATE OF OPERATION 6/19/67	
22. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary Emboli		23. AUTOPSY? (Yes or No) Yes		24. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
28. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		29. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		30. HOW DID INJURY OCCUR?	
31. I certify that (1) (this hospital) attended the deceased from 6/19 1967 to 6/19 1967.		32. that (1) (we) lost saw the deceased alive on 6/19 1967 and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		33. SIGNATURE R. L. Hursey M.D.	
34. DATE SIGNED 6/19/67		35. PHYSICIAN'S NAME (Type) Richard L. Hursey M.D.		36. ADDRESS Johns Hopkins Hosp	
37. BURIAL CREMATION, REMOVAL (Specify) Burial		38. DATE 6/23/67		39. NAME OF CEMETERY or CREMATORY Meadowridge Memorial	
40. LOCATION (City, town, or county) Howard County		41. (State) Md.		42. DATE REC'D BY HEALTH DEPT. JUN 22 1967	
43. NAME OF REGISTRAR Robert E. Taylor M.D.		44. FUNERAL DIRECTOR C. F. EVANS & SON		45. ADDRESS 8802 Harford Rd.	

*Handwritten signature/initials*

*Handwritten text: 6-30-67, 10:00 AM, 10:00 AM, 10:00 AM*

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*Handwritten text: 10:00 AM, 10:00 AM, 10:00 AM*

*Handwritten text: 10:00 AM*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		Registered No. <b>67 6032</b>	
BIRTH NO. <b>67 6032</b>		<b>CERTIFICATE OF DEATH</b>					
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Patricia M. Taylor</b>		2. DATE AND HOUR OF DEATH <b>June 20, 1967</b> <b>9:50</b> <b>P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>HARFORD</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Edgewood</b> D. STREET ADDRESS (If rural, give location) <b>411 Kennard Ave</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never married</b>	8. DATE OF BIRTH <b>11/24/46</b>	9. AGE (In years lost birthday) <b>20</b>	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10B. KIND OF BUSINESS OR INDUSTRY				
13. FATHER'S NAME <b>Joseph</b>			14. MOTHER'S MAIDEN NAME <b>LAURA OCHAL</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. <b>600.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>chronic pyelonephritis</b>				CAUSE OF DEATH (A) <b>Uremia</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>4-5 months</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 7, 1967</b> to <b>June 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 20, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John Smith</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>6/20/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>Jere P. Smith</b>				23D. ADDRESS M.D. <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/24/67</b>		24C. NAME of CEMETERY or CREMATORY <b>ST. STANISLAUS</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>C.F. EVANS &amp; SON, INC. BALTO. MD.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6033				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 6033	
1. NAME OF DECEASED (Type or Print) <b>Mollie Knight</b>				2. DATE AND HOUR OF DEATH <b>6/19/67 10:50 P</b>					
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Frederick</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Fredale</b>					
				D. STREET ADDRESS (If rural, give location) <b>570 - Enelem Ave</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>		8. DATE OF BIRTH <b>6-17-98</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George Phillips</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Bourdee</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Elaine Knight</b>		ADDRESS <b>841 Clifton Ave Arnold, Md.</b>	
18. <b>433.014-203X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>cardiac arrest</b>				CAUSE OF DEATH (A) DUE TO <b>ASCVD</b>				INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>multiple myeloma</b>				(B) DUE TO <b>6 mo.</b>					
(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>6/11/67</b> to <b>6/19/67</b> , that (2) (we) lost saw the deceased alive on <b>6/19/67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <b>E. P. Wilkinson</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6/19/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>CHARLES P. WILKINSON</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>June 23, 67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, AA. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>A. V. Singleton</b>		ADDRESS <b>Glen Burnie, Md.</b>			

Handwritten notes at the top of the page, including the date "April 10, 1900" and the name "J. H. ...".

Housework can be done better and

more quickly. Mrs. Elsie Knight

No

Handwritten notes at the bottom of the page, including the name "A. J. ...".



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 6034	
BIRTH NO. 67 6034		CERTIFICATE OF DEATH						67 6034			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARTHA H. JOHNSON						2. DATE AND HOUR OF DEATH 6/20/67		245 an M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 16 15-93 D. STREET ADDRESS (If rural, give location) 1500 N. Smallwood					
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		(If not in hospital or institution, give street address or location)		5. SEX Female		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 4/20/1910	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		9. AGE (In years last birthday) 57		12. CITIZEN OF WHAT COUNTRY? U.S.A.		If Under 1 Yr. Months: Days	
13. FATHER'S NAME Herbert HALL		14. MOTHER'S MAIDEN NAME Winnie Wright		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-12-8708		17. INFORMANT Houston A. Johnson - 1500 Smallwood St.		ADDRESS	
18. 239X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ? Multiple Pulm Emboli DUE TO (B) Tumor, Coagulopathy DUE TO (C)						INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 6/4/67 to 6/20/67, that (I) (we) last saw the deceased alive on 6/20/67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE R. Rampton						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/20/67			
23C. PHYSICIAN'S NAME (Type) RALPH R. RAMPTON						23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-23-67		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) Baltimore, Maryland (State)					
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave. ADDRESS							

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-11370 67 6035				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6035	
1. NAME OF DECEASED (Type or Print) <b>Baby BOY-AMANDA BROWN</b>				2. DATE AND HOUR OF DEATH <b>6-14-67 13<sup>30</sup> A M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospital #21224 4940 Eastern Ave. Baltimore, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2406 Francis St. 21217 007</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>		8. DATE OF BIRTH <b>6-13-67</b>	9. AGE (In years last birthday) <b>26</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <b>1</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A. (MD.)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE BROWN</b>				14. MOTHER'S MAIDEN NAME <b>AMANDA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>21224 RECORDS-BCM-4940 EASTERN AVENUE, BALTIMORE</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY DISTRESS</b>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PREMATURITY</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6-13-67</b> to <b>6-14-67</b> that (I) <u>(we)</u> last saw the deceased alive on <b>6-14-19 67</b> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <b>E. McHugh</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> <b>HOUSE</b>		23B. DATE SIGNED <b>6-14-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>EVA R. McHUGH</b>				23D. ADDRESS <b>4940 Eastern Ave. Baltimore, Md. Mature Nursery, Baltimore City Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>6-14-67</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore City Hospitals</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21224</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>HOSPITAL DISPOSAL</b>			



J-5251

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6036		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6036	
M.E. CASE NO. 1. NAME OF DECEASED (Type as Print) <b>JOHNSON, JESSIE</b>			2. DATE AND HOUR OF DEATH <b>6/21/67 11<sup>00</sup> A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MD. Hospital</b> <b>LOMBARD &amp; GREENE ST.</b> <b>BALTO. MD 21201</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 1801</b>		
D. STREET ADDRESS (If rural, give location) <b>317 N. Schroeder St.</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>3/20/92</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>NOAH JOHNSON</b>			14. MOTHER'S MAIDEN NAME <b>JULIA FELD</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>CHART</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PERITONITIS &amp; SEPSIS</b>		CAUSE OF DEATH (A) DUE TO <b>Post-Operative Small Bowel Fistula</b> (B) DUE TO <b>Today</b> (C)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Probable Pulmonary Infection</b>		<b>18 days</b>	
19A. DATE OF OPERATION <b>6/26/67</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Small Bowel Hernia</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (his hospital) attended the deceased from <b>6/1</b> 19 <b>67</b> to <b>6/21</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/21</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Irvin M. Sopher MD</b>			23B. DATE SIGNED <b>6/21/67</b>		
23C. PHYSICIAN'S NAME (Type) <b>IRVIN M. SOPHER</b>			23D. ADDRESS <b>University of Md. Hospital</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/24/67</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cem.</b>	24D. LOCATION <b>BALTO. MD.</b>	24E. (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		25D. ADDRESS <b>317 N. Schroeder St.</b>	

MC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 6037</span>
BIRTH NO. <span style="float: right;">67 6037</span>		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ADA GAVIN</b>		2. DATE AND HOUR OF DEATH <b>8 6-17-67 9:20AM M.</b>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>3-01</b> D. STREET ADDRESS (If rural, give location) <b>1613 EAST BALTIMORE STREET</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>8-4-1883</b>	9. AGE (In years lost birthday) <b>84</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Fretz</b>		14. MOTHER'S MAIDEN NAME <b>Marie Fritz</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Lydia Fretz R.2 Box 318 Quakertown Pennsylvania</b>	
18. <b>463X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Coronary Arrest</b> DUE TO (B) <b>? Pulmonary Embolus</b> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH _____		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Mucous secretions, Adiposarcoma</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/18</b> 19 <b>67</b> to <b>6/17</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/17</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Kenneth L. Brigham</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/17/67</b>
23C. PHYSICIAN'S NAME (Type) <b>Kenneth L. Brigham</b>		23D. ADDRESS M.D. <b>JOHNS HOPKINS HOSPITAL - BALTIMORE, MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6-22-67</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967 Robert E. Taylor</b>		25B. NAME OF REGISTRAR		
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc.</b>		ADDRESS <b>1218 St. Paul St. Balti., Maryland</b>		

W



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 6038

BIRTH NO.  
M.E. CASE NO.

67 6038

1. NAME OF DECEASED  
(Type or Print)

PAUL

L.

SCHEMEHLING

2. DATE AND HOUR PRONOUNCED DEAD

June 20, 1967

10:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1828 St. Paul Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1828 St. Paul Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

XXXXX 4/16/14

9. AGE (in years  
last birthday)

57 53

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Pipe Fitter

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Schmehling

14. MOTHER'S MAIDEN NAME

Theresa Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 11

16. SOCIAL  
SECURITY NO.

215-07-0355

17. INFORMANT

ADDRESS

Balt. Md.

Mrs Mary Schmehling XXXX 1828 St. Paul St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/21/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/26/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Catonsville, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 22 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS

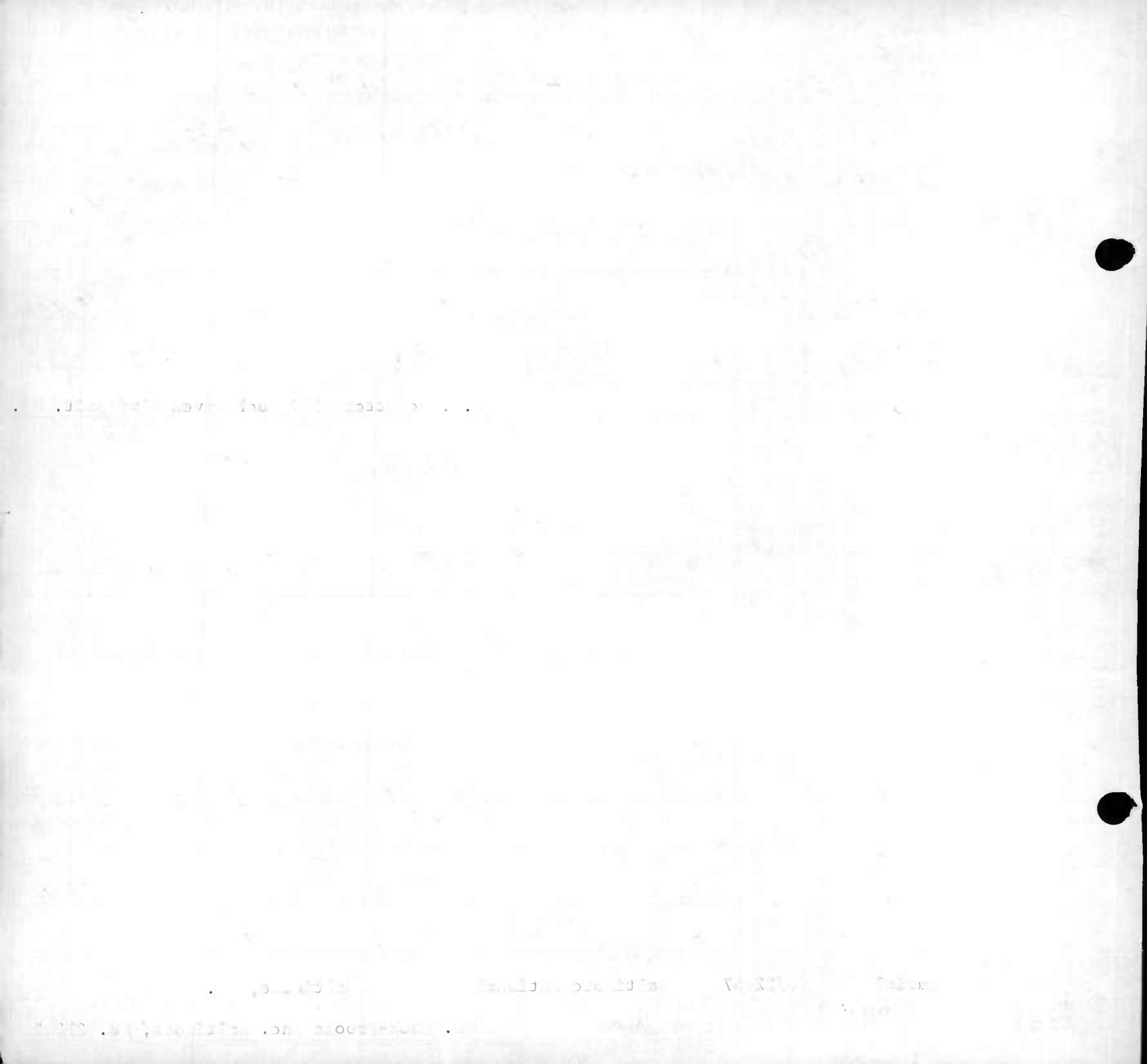
Wm. Cook-Brooks Inc. Baltimore, Md. 21202



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6039</u>
BIRTH NO. <u>67 6039</u>		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>RENA SNOVELL</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH <u>6/19/67</u> <u>11:50</u> a.m.		
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>11-01</u> D. STREET ADDRESS (If rural, give location) <u>915 ST PAUL ST</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH <u>12/13/1898</u>	9. AGE (In years last birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NO. CAROLINA</u>
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		13. FATHER'S NAME <u>BRADFORD MCCOTTER</u>		
14. MOTHER'S MAIDEN NAME <u>JENNIE SAWYER</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>W.V. McCotter 8219 Loch Raven Blvd Balt. Md.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>199.1 I</u> <u>TERMINAL CANCER</u>		INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>SGUAMOUS CELL CARCINOMA</u> (C) <u>OF METASTASIS</u>		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>5/100/67</u> 19 <u>67</u> to <u>6/19</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/19/67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Arturo Norico</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/19/67</u>
23C. PHYSICIAN'S NAME (Type) <u>ARTURO NORICO</u>		23D. ADDRESS <u>MERCY HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/22/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National</u>
24D. LOCATION <u>Baltimore, Md.</u>		24E. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 22 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</u>



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6040</b>	
BIRTH NO. <b>67 6040</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>HOUSTON MRS VIRGINIA</b>		2. DATE AND HOUR OF DEATH <b>6-19-67 3:50 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME &amp; HOSP.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>6-04</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1804 E. FAIRMOUNT AVE. (31)</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>2-14-04</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>	
13. FATHER'S NAME <b>LORING RICE</b>			12. CITIZEN OF WHAT COUNTRY? <b>AMR.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHURCH HOME &amp; HOSP.</b>
18. <b>330X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.) <b>SUBARACHNOID HAEMORRHAGE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPERTENSION</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>32 days</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-17-1967</b> to <b>6-19-1967</b> , that (I) (we) last saw the deceased alive on <b>5-19-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rodilio M. Lina</b> M.D.				23B. DATE SIGNED <b>6-19-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Rodilio M. Lina</b> M.D.				23D. ADDRESS <b>Church Home &amp; Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/23/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven</b>	
24D. LOCATION (City, town, or county) (State) <b>AA County Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</b>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6041				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6041	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>PATTERSON, CHARLES</b>				2. DATE AND HOUR OF DEATH <b>6-17-67</b> <b>9:30AM</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>7-00</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) <b>633 NORTH CASTLE STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7-4-85</b>	9. AGE (In years lost birthday) <b>81</b>	If Under 1 Yr. Months Days Hours	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
?		?		?		?	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>				16. SOCIAL SECURITY NO. ?		17. INFORMANT <b>Nicely Funeral Home Clifton Forge, Va.</b>	
18. <b>437X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BILE PERITONITIS</b> (A) DUE TO <b>DEHISCENCE OF FINNEY</b> <b>PYLOROPLASTY X II</b> (B) DUE TO <b>BLEEDING STRESS ULCER-GASTRIC</b> <b>BLEEDING ABDONINAL AORTIC ANEURYSM</b> (C) DUE TO <b>5-23 -6-17</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6-6 TO 6-17</b> <b>6-6- TO 6-17</b> <b>6-12 6-17</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>A S C V D RENAL FAILURE</b>			
19A. DATE OF OPERATION <b>5-24-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>AORTIC ANEURYSM</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6-1-</b> <b>19 67</b> to <b>6-17-67</b> <b>19</b> that (I) (we) last saw the deceased alive on <b>6-17-</b> <b>19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Richard G. Parry</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <b>6-17-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD C. PARRY</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>6/18/67</b>		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>Clifton Forge, Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MA</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</b>			

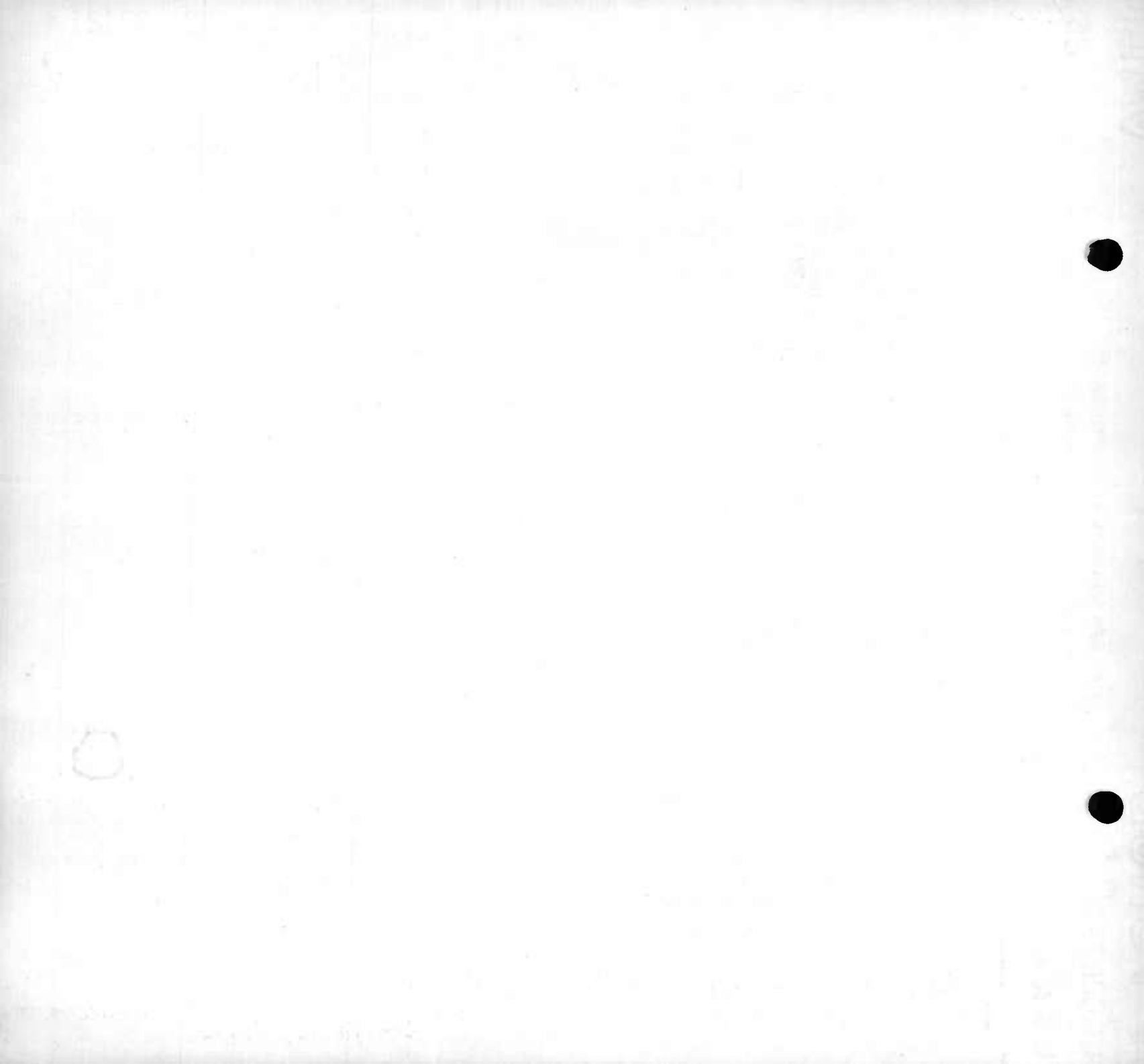




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

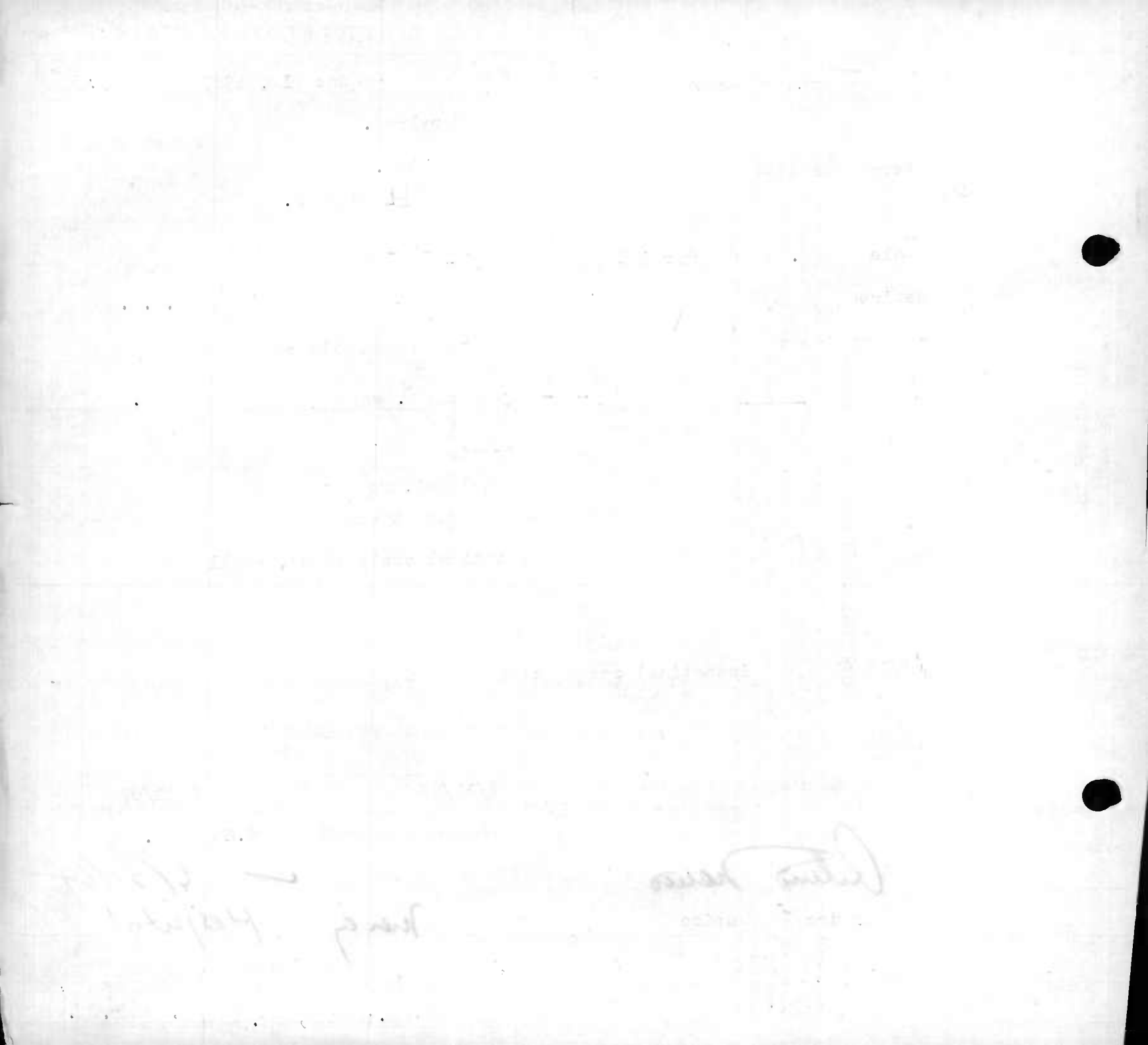
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6042</b>	
BIRTH NO. <b>67 6042</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <b>NELSON FORTSON</b>		2. DATE AND HOUR OF DEATH <b>6/11/67</b> <b>1 8 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> 8. COUNTY <b>18-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY MARYLAND</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>852 W. VINE ST.</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. <del>MARRIED, NEVER MARRIED</del> <b>WIDOWED, DIVORCED</b> (specify)		8. DATE OF BIRTH <b>2/15/02</b>	9. AGE (In years lost birthday) <b>65</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GEORGIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WHITE FORTSON</b>		14. MOTHER'S MAIDEN NAME <b>HATTIE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-3208</b>		17. INFORMANT <b>PATIENT</b>	
18. <b>433.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>CARDIO-RESP ARREST</b> DUE TO (B) <b>ASCVD to CHF +</b> DUE TO (C) <b>ARRHYTHMIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24-36 HRS.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JUNE 9</b> 19 <b>67</b> to <b>JUNE 11</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>JUNE 11</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William H. Barker, Jr.</b> M.D.				23B. DATE SIGNED <b>6/11/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM H. BARKER, JR. M.D.</b>				23D. ADDRESS <b>UNIV. HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-17-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>mt Auburn Cemetary</b>	
24D. LOCATION (City, town, or county) (State) <b>Balt. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Barker</b>		25C. FUNERAL DIRECTOR <b>Joseph L. Russ</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">67 6043</span>	
BIRTH NO. <span style="font-size: 1.2em;">67 6043</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Joseph A Cooney</span>			June 21, 1967 <span style="float: right;">5:55 P.M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.1em;">Mercy Hospital</span>			A. STATE <span style="font-size: 1.1em;">Maryland.</span>		
			B. COUNTY <span style="font-size: 1.1em;">9-03</span>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.1em;">Balto.</span>		
D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.1em;">3608 Elkader Rd.</span>					
5. SEX <span style="font-size: 1.1em;">Male</span>	6. RACE <span style="font-size: 1.1em;">W.</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.1em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.1em;">7-26-85</span>	9. AGE (In years last birthday) <span style="font-size: 1.1em;">81</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Retired (Clerk)</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.1em;">Banking</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">U.S.A.</span>					
13. FATHER'S NAME <span style="font-size: 1.1em;">Thomas Cooney</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Joahanna Kelloher Harvey</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">215-07-5505</span>		17. INFORMANT ADDRESS <span style="font-size: 1.1em;">Anna M. Cooney 3608 Elkader Rd.</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.1em;">Uremia</span>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO <span style="font-size: 1.1em;">Renal Failure</span>		
			(B) DUE TO <span style="font-size: 1.1em;">Bladder tumor</span>		
			(C) <span style="font-size: 1.1em;">Intestinal obstruction, Small</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.1em;">6/19/67</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.1em;">intestinal obstruction</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">No</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">6/14/67</span> 19 to <span style="font-size: 1.1em;">6/21/67</span> 19, that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">6/21/67</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. At <span style="font-size: 1.1em;">6.05 P.M.</span>					
23A. SIGNATURE <span style="font-size: 1.1em;">Arturo Norico</span>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.1em;">6/21/67</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">Arturo Norico</span>		23D. ADDRESS <span style="font-size: 1.1em;">Mercy Hospital</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">6/24/67</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.1em;">Holy Redeemer Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore Maryland</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">JUN 22 1967</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">Robert E. Stanley</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.1em;">John A. Moran, Inc. 3000 E. Balto. St.</span>	



1  
N. 636

67 6044

BALTIMORE CITY HEALTH DEPARTMENT

67 6044

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE

B.

NORTHERN

2. DATE AND HOUR PRONOUNCED DEAD

June 21, 1967

9:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-38

D. STREET ADDRESS (If rural, give location)

1602 Glen Eagle Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5/15/1911

9. AGE (In years  
last birthday)

56 54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Montana

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert J. Northern

14. MOTHER'S MAIDEN NAME

Ellen Gifford

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL  
SECURITY NO.

218127866

17. INFORMANT

ADDRESS

Mrs. Helen R. Northern- 1602 Gleneagle Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Subarachnoid Hemorrhage  
DUE TO rupture of aneurysm of Circle of  
Willis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/21/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

23B. DATE

6/24/67

23C. NAME of CEMETERY or CREMATORY

Greenmount Crematory

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 22 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

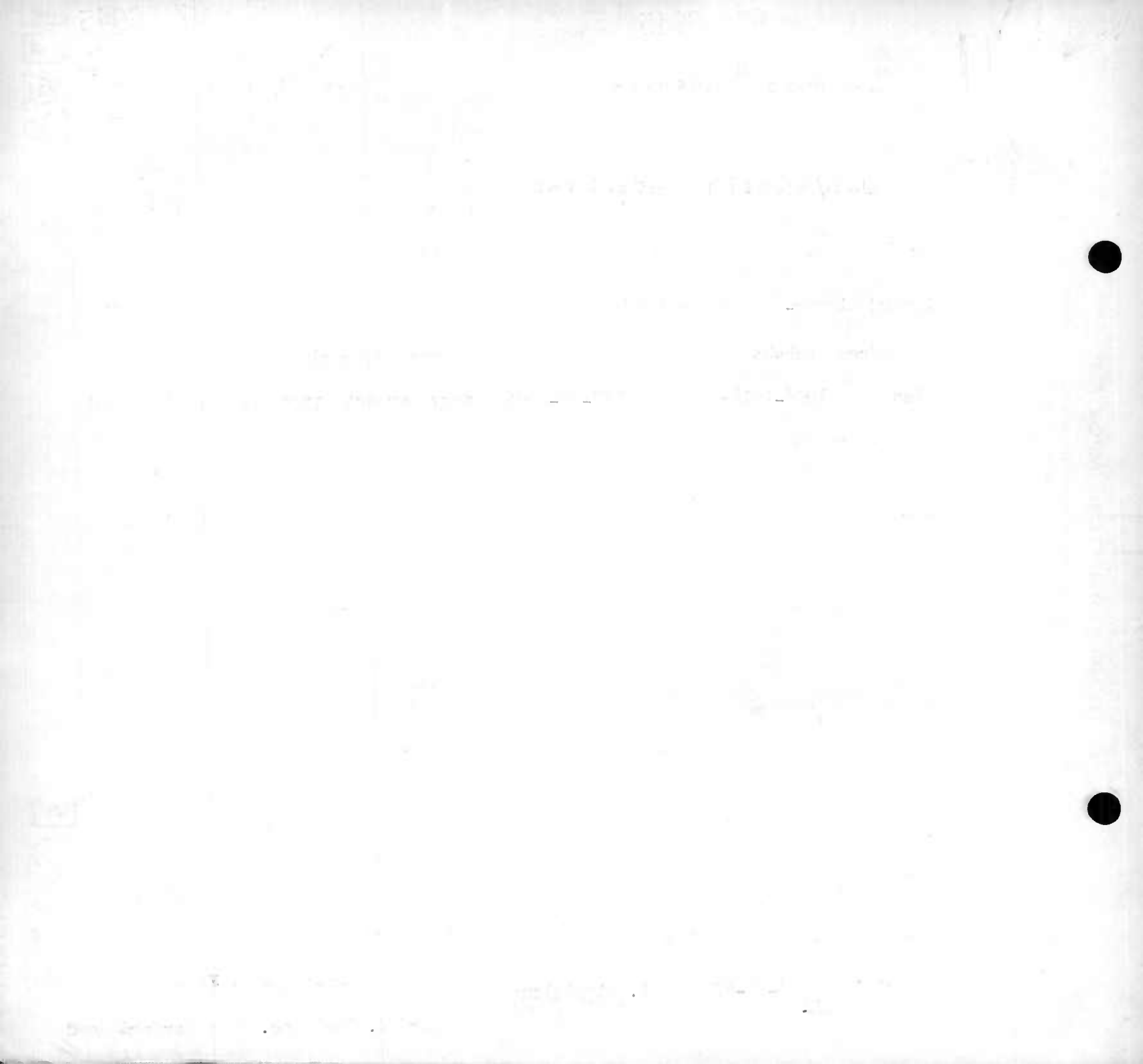
Leonard J. Ruck Inc. 5305 Harford Rd. #14

WILLIAM PORTER

# FUNERAL DIRECTOR: IMPORTANT

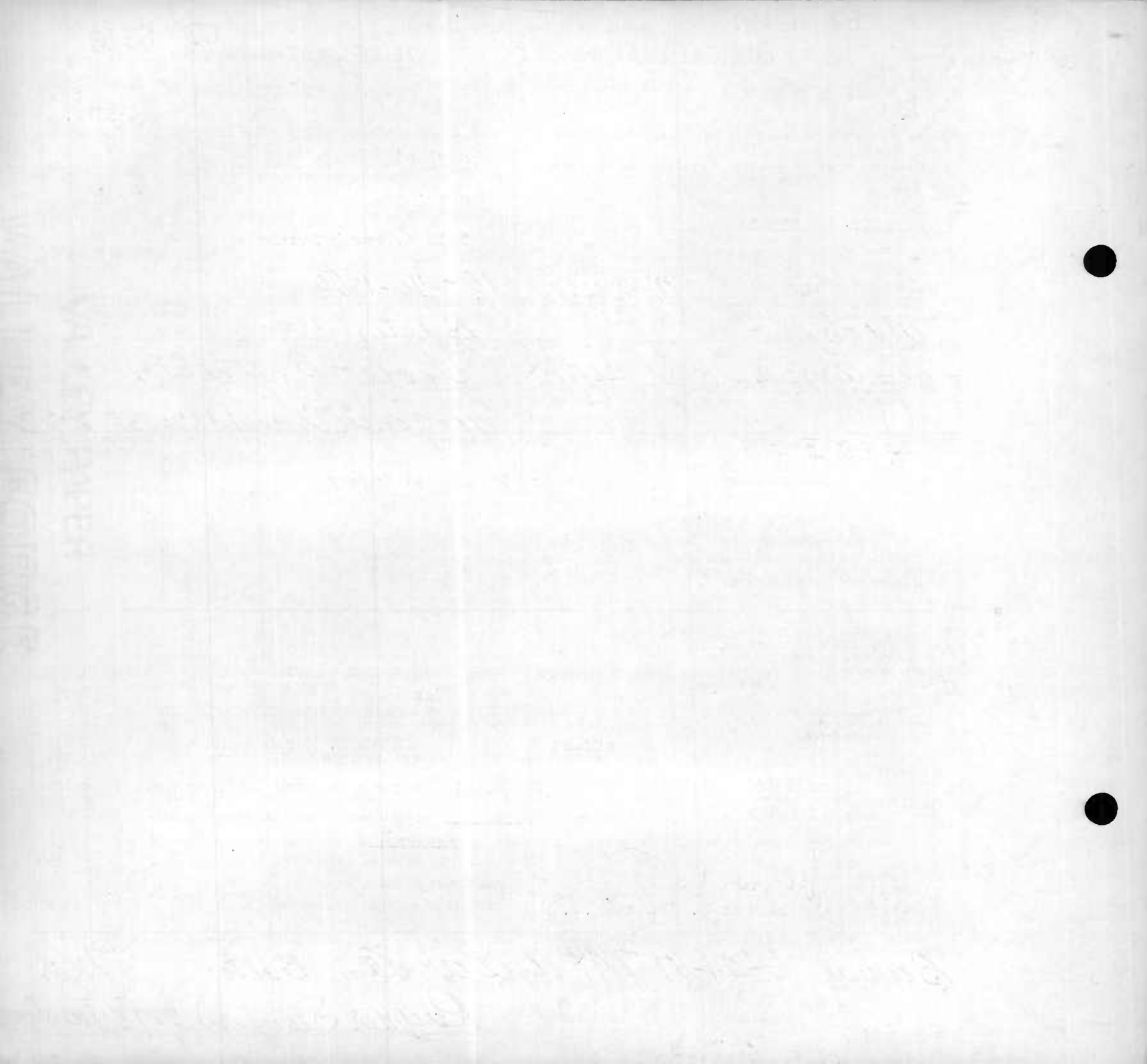
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 6045		Registered No. 67 6045	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>LAWRENCE H. RACHUBA</b>				2. DATE AND HOUR OF DEATH <b>JUNE 21, 1967 8 27 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>HEATHER HILL RD. 1325 Heather Hill Rd.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <del>WIDOWED</del> DIVORCED (specify)	8. DATE OF BIRTH <b>1/15/89</b>	9. AGE (In years lost birthday) <b>78</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipyard Rigger-</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew Rachuba</b>				14. MOTHER'S MAIDEN NAME <b>Anna Ragacyak</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1906-1914</b>		16. SOCIAL SECURITY NO. <b>213-09-2065</b>		17. INFORMANT ADDRESS <b>Harry Dorbert 1325 Heather Hill Road</b>			
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>intracerebral hemorrhage</b> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>11 hours</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>possible aspiration pneumonia</b> DUE TO <b>HASCUP</b>				<b>11 hours</b> <b>?</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>BPH, chronic prostatitis, chronic obst. lung disease</b>							
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>6/20/67</u> 19 to <u>6/21/67</u> 19, that (I) <u>(we)</u> lost saw the deceased alive on <u>6/21/67</u> 19 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> <u>(We)</u> <u>(Did)</u> (did not) view the body after death.							
23A. SIGNATURE <b>Anne C. Colston</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/21/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ANNE C. COLSTON</b>				23D. ADDRESS <b>UNIV. HOSP</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-24-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. 5305 Harford Road</b>			









# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 6047</b>	
BIRTH NO. <b>67 6047</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>5.10 pm June 21. 1967</b>	
1. NAME OF DECEASED (Type or Print) <b>LAMOND, FRANCIS ANDREW</b>		M. <b>27-14</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Union Memorial Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
		D. STREET ADDRESS (If rural, give location) <b>4639 SCHENCK RD</b>	
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>07-20-15</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HUTZLER BROS.</b>	9. AGE (In years last birthday) <b>51</b>
11. BIRTHPLACE (State or foreign country) <b>MD. LAWRENCE, MASS.</b>		12. CITIZEN OF WHAT COUNTRY <b>(USA) AMERICAN</b>	
13. FATHER'S NAME <b>IGNATIUS LAMOND</b>		14. MOTHER'S MAIDEN NAME <b>MILDRED HICKEY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>220-14-1969</b>	17. INFORMANT <b>MRS. HELEN LAMOND</b>
		ADDRESS <b>(SAME)</b>	
18. <b>4-20-11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b>		CAUSE OF DEATH (A) DUE TO <b>Coronary arteriosclerotic heart disease</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>Ant</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1.20 pm June 21 1967</b> to <b>5.10 pm June 21 1967</b> , that (I) (we) last saw the deceased alive on <b>5.10 pm June 21 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Sang Won Song</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>June 21, 1967</b>
23C. PHYSICIAN'S NAME (Type) <b>SANG WON SONG,</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/24/1967</b>	24C. NAME of CEMETERY or CREMATORY <b>Moreland Mem. Pk.</b>	24D. LOCATION (City, town, or county) (State) <b>Parkville, Balto. Co., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Edley</b>	25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>

LAMOND, FRANK, ANDREW 2-10-21 10:00 AM

IND

The Union Memorial Hospital  
423 S. SCHUBERT RD  
BALTIMORE

WHITE M 07-20-21 21

MD AMERICAN

MILDRED HICKEY LAMOND

General and obstetric  
Robertson Adams

Box

YES

YES

2-10-21 10:00 AM 2-10-21 10:00 AM

X

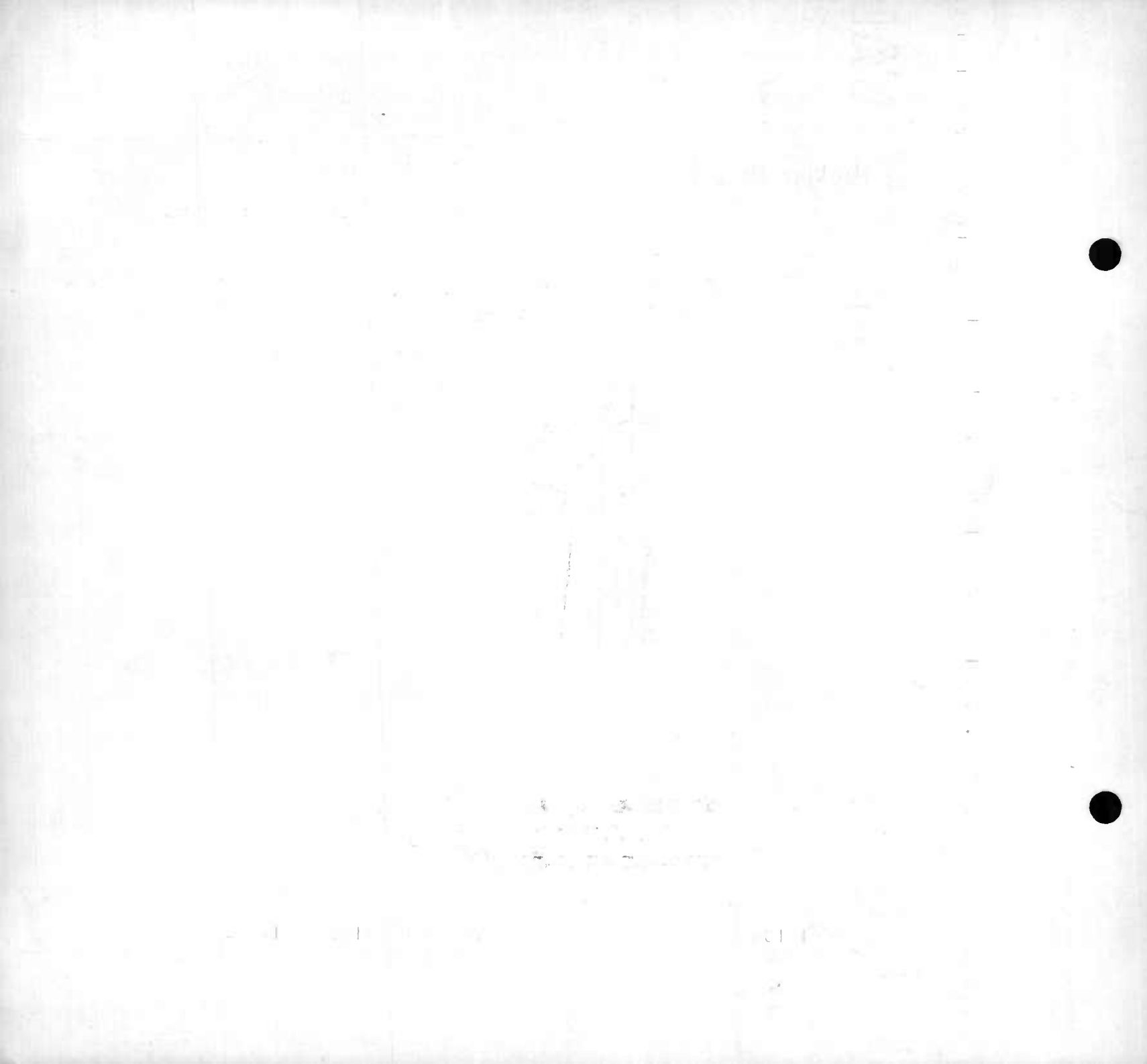
and 1000

THE

# FUNERAL DIRECTOR: IMPORTANT

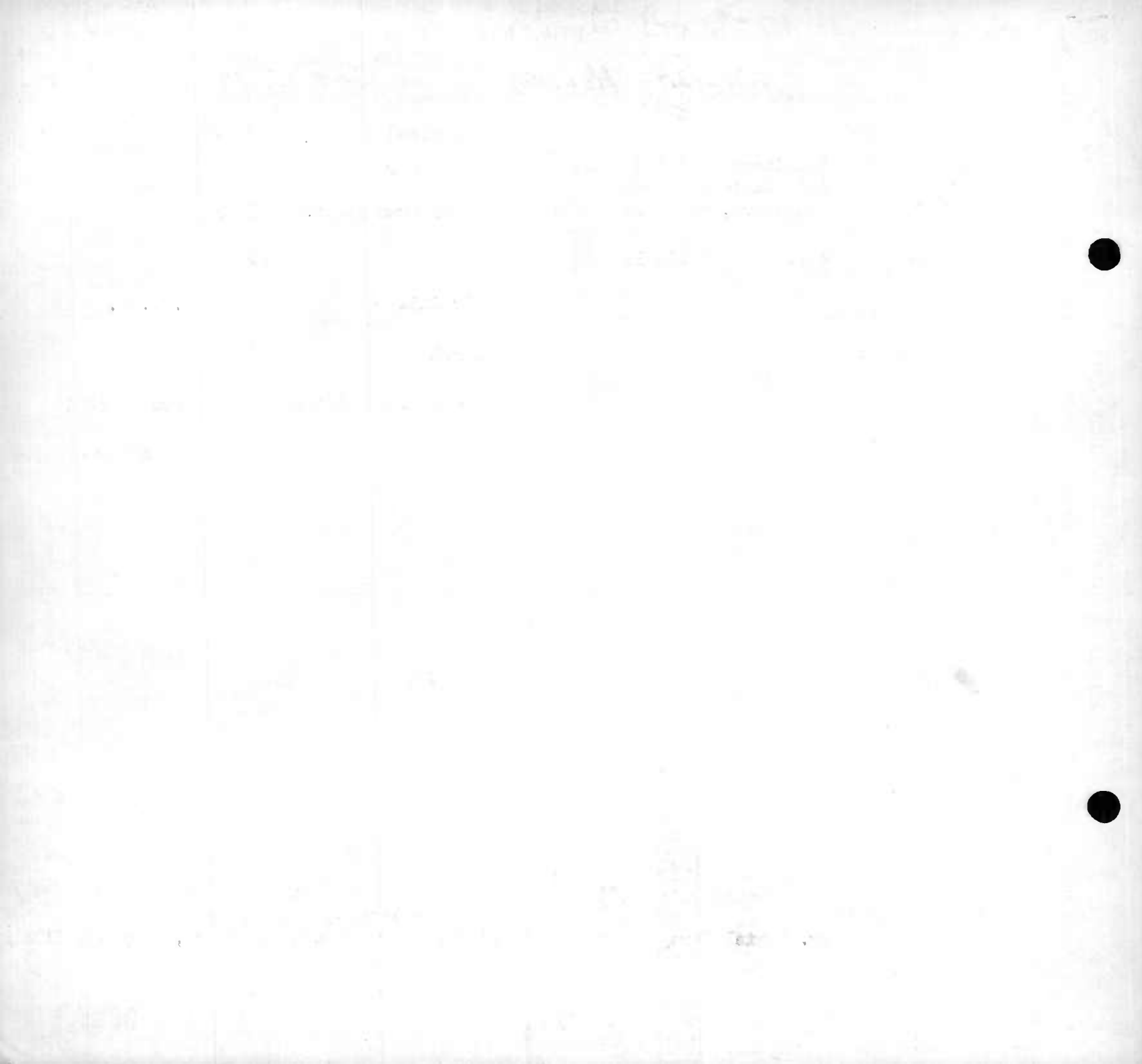
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-05792 67 6048		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6048	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Campbell, Carol Lynn		2. DATE AND HOUR OF DEATH 11 AM 6/18/67 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 1722 Terrell Place		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 8-06			
D. STREET ADDRESS (If rural, give location) 1722 Terrell Place					
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) —	8. DATE OF BIRTH 3/24/67	9. AGE (In years last birthday) 3 months 3	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10B. KIND OF BUSINESS OR INDUSTRY Father of child Crown Terminal Warehouse		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Campbell, Thomas			
14. MOTHER'S MAIDEN NAME Taylor, Loretta		15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.		17. INFORMANT Father Campbell, Thomas, 1722 Terrell Pl			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 6/18 1967 9 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mona Belinic		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/20/67	
23C. PHYSICIAN'S NAME (Type) MONA BELINIC		23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) JUN 20 1967		24B. DATE JUN 20 1967			
24C. NAME OF CEMETERY ANATOMY BOARD OF MARYLAND		24D. NAME OF CEMETERY UNIVERSITY MEDICAL SCHOOL			
25A. DATE REC'D BY HEALTH DEPT. JUN 23 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	
25D. ADDRESS					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6049	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
WILLIAM HOLMES			JUNE 15, 1967 2:57 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2235 Orem Avenue 21217		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
Male	Negro	Single		65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Virginia		U. S. A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Abraham			Sarah		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT ADDRESS		
			RECORDS: BCH 4940 Eastern Avenue 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			A. DUE TO B. DUE TO C. DUE TO		4 days.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from 6/15 to 6/15 19 67 and that (I) <del>(we)</del> lost saw the deceased alive on 6/15 19 67 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Dr. Daniel Tarsy			JUNE 15, 1967		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. Daniel Tarsy			Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORIUM	
		JUN 22 1967		ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 23 1967		Robert E. Tarsy		UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	





BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RICHARD

A.

BANKS

2. DATE AND HOUR PRONOUNCED DEAD

June 20, 1967

8:24 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Apt. 9 C - 130 Aisquith Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 28, 1911

9. AGE (In years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Richard A. Banks

14. MOTHER'S MAIDEN NAME

Emma Beale

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

220-05-2727

17. INFORMANT

ADDRESS

Mrs. Margaret Bakns

616 Grantley St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenio, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinoma of Urinary Bladder  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/21/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/24/67

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore,

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 23 1967

24B. NAME OF REGISTRAR

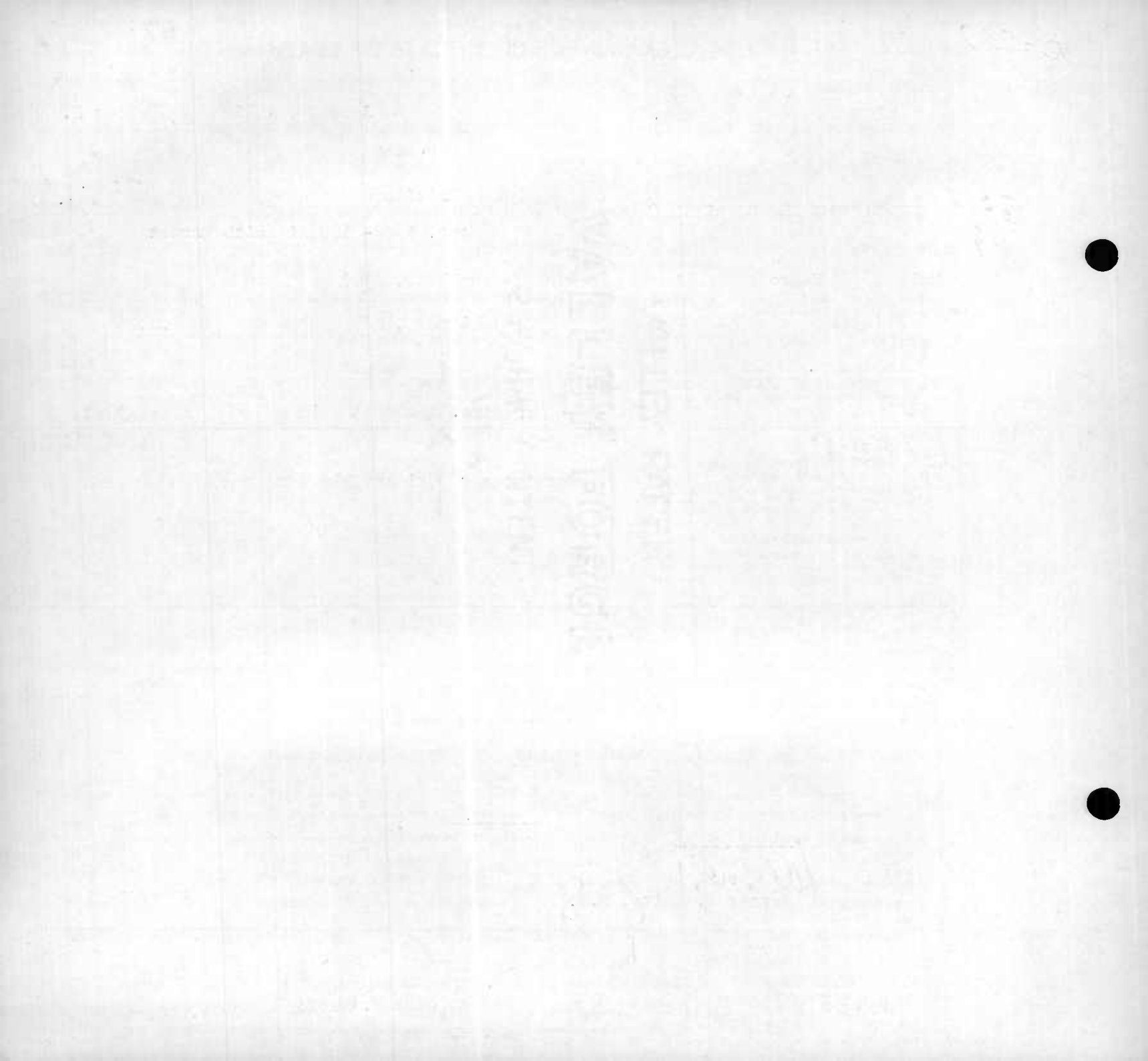
Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

ADDRESS

Herbert E. Nutter

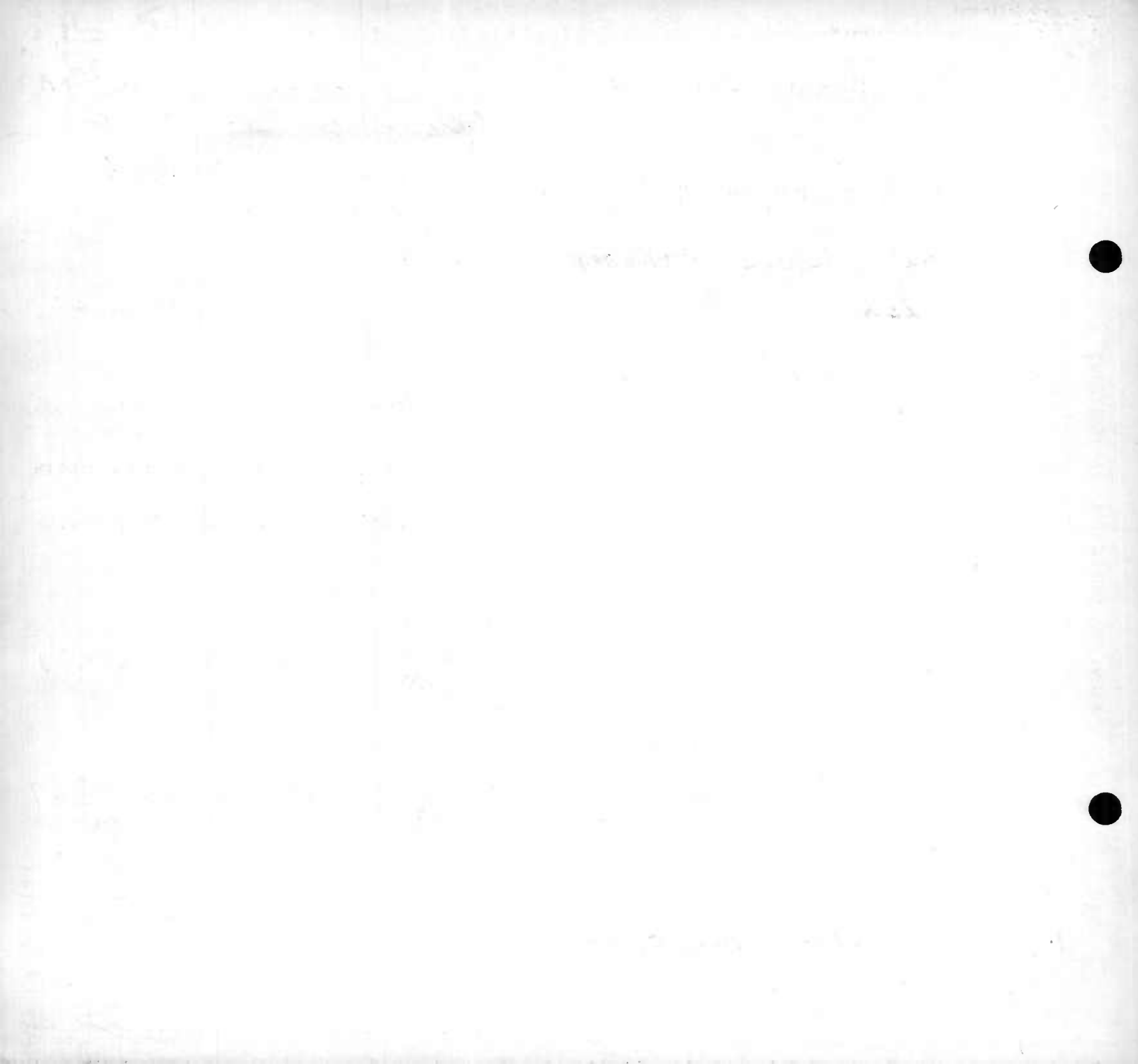
3035 W. North Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6051		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6051	
M.E. CASE NO.			1. NAME OF DECEASED		
(Type or Print) HARRIS JOHN N.			2. DATE AND HOUR OF DEATH 6-20-67 12:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE MARYLAND		
Lutheran Hospital of Maryland			B. COUNTY Baltimore, Maryland		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Baltimore, Maryland			639 N. BENTLEY ST		
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3-11-1890	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY AMERICAN SMELTING CO	11. BIRTHPLACE (State or foreign country) CHARLES CITY CO, VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-1563	17. INFORMANT ADDRESS Dr. N. ALAN HARRIS 3310 Walbrook Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)			(A) DUE TO Pulmonary emboli		sudden death
			(B) DUE TO Arteriosclerotic heart disease		3 years
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-12-1967 to 6-20-1967, that (I) (we) last saw the deceased alive on 6-20-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nguyen Thi Oanh				23B. DATE SIGNED 6-20-67	
23C. PHYSICIAN'S NAME (Type) NGUYEN THI OANH				23D. ADDRESS Lutheran Hospital of Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/24/67		24C. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK	
24D. LOCATION		24E. CITY, TOWN, OR COUNTY		24F. STATE	
Arbutus		Baltimore		Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 23 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS HERBERT E. NUTTEN 3035 W. NORTH AVE	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

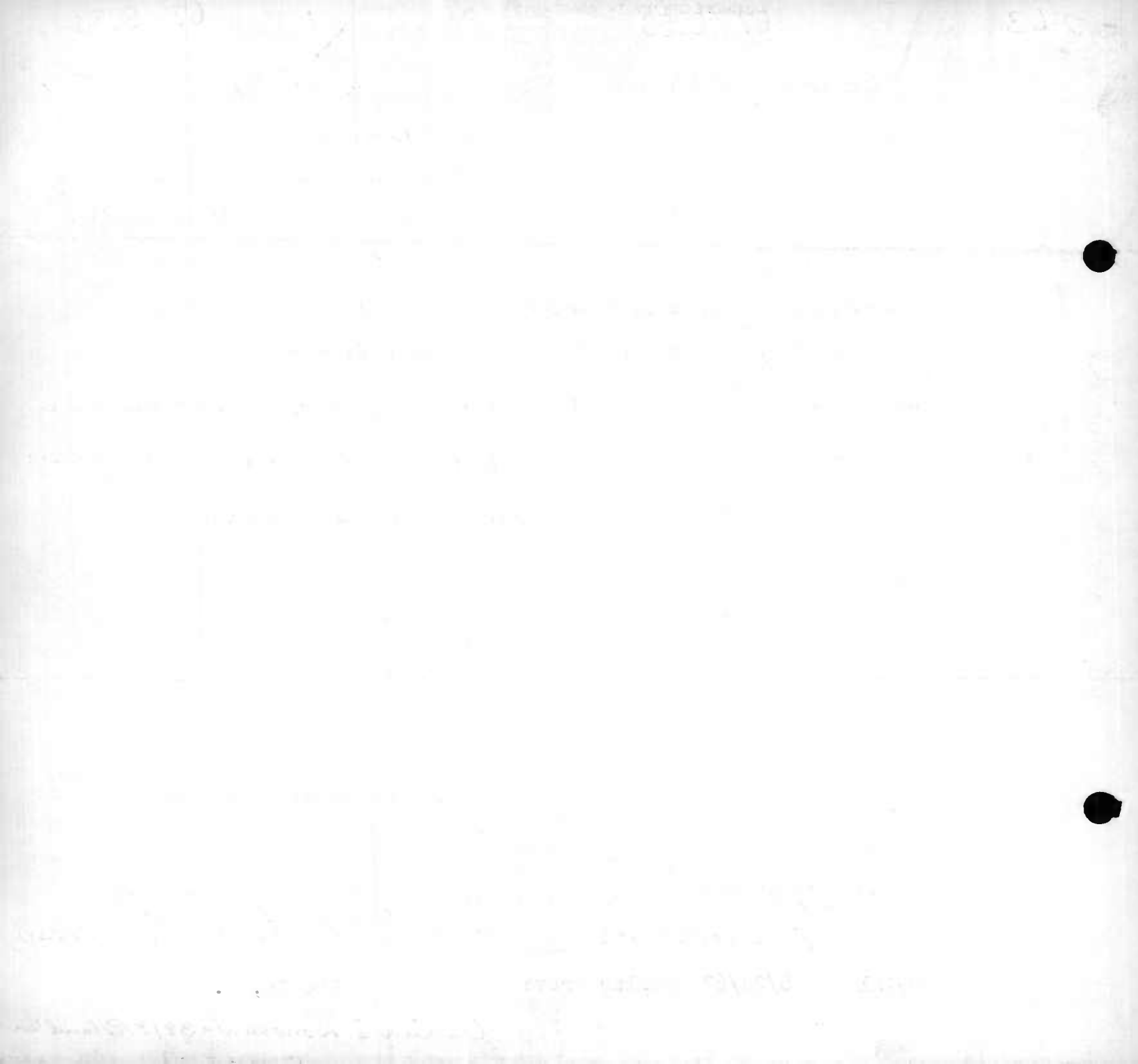
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <span style="float: right;">67 6052</span>	
BIRTH NO. <span style="float: right;">67 6052</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>LENA WILLIAMS</b>		2. DATE AND HOUR OF DEATH <b>6-20-67 3:10 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>X</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland #21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>1617 Balmor Ct. #21217</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>3-31-01</b>	9. AGE (In years lost birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Goldsboro, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Powell</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Sherrod</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>4940 Eastern Avenue BCH: RECORDS Baltimore, Maryland #21224</b>			
18. <b>203X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Multiple Myeloma</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Essential Hypertension</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6-5</b> 19 <b>67</b> to <b>6-20</b> 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>6-20</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Jeffrey D. Aaronson</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-20-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jeffrey D. Aaronson</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Md. #21224</b>			
24A. BURIAL-CREATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/24/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus Balto Co, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 23 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Parker</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter 3035 W. North Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6053		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6053	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Eckert Edward</i>		2. DATE AND HOUR OF DEATH <i>6-21-67</i> <i>9:45</i> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>6057 FALLS RD. 21209</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital.</i>		(If not in hospital or institution, give street address or location)		5. SEX <i>M.</i>		6. RACE <i>W.</i>	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M.</i>		8. DATE OF BIRTH <i>10-8-16</i>		9. AGE (In years last birthday) <i>50</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CHAUFFEUR.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>FEDERAL BOARD</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Joseph L. ECKERT</i>		14. MOTHER'S MAIDEN NAME <i>EMMA SHUNBACKER</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>1</i>	
17. INFORMANT <i>CATHERINE ECKERT-6057 FALLS RD.</i>		ADDRESS		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Aortic stenosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>42 years</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. CAUSE OF DEATH (A) DUE TO <i>Rheumatic Heart disease</i> (B) DUE TO (C)		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Possible Acute Cholelithiasis</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6-21-10:15 AM 1967</i> to <i>6-21 9:45 1967</i> , that (I) (we) last saw the deceased alive on <i>6-21 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Jose V. Iglesias</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/21/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Jose V. IGLESIAS</i>		23D. ADDRESS <i>1213 Light St. Baltimore 21230</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/24/67</i>	
24C. NAME of CEMETERY or CREMATORY <i>Poplar Grove</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Co., Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 23 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>	
25C. FUNERAL DIRECTOR <i>Austin E. Donovan</i>		ADDRESS <i>3818 Roland Ave</i>					





Released by Med. Examiner, Dr. Spitz at 11:30 AM 6-21-67  
FURNERAL DIRECTOR: IMPORTANT

BIRTH NO. 67 6054				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6054	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CLARK John				2. DATE AND HOUR OF DEATH 6-21-67 9 AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hosp.				A. STATE M.D. Baltimore 53-00			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - Sparrows Point			
				D. STREET ADDRESS (If rural, give location) Rt. #10 Box 355 Sp. Point			
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPARATED		8. DATE OF BIRTH 12-21-02	
						9. AGE (In years lost birthday) 64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman		10B. KIND OF BUSINESS OR INDUSTRY Rheem Manufacturing Co.		11. BIRTHPLACE (State or foreign country) MD Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Harry Clark				14. MOTHER'S MAIDEN NAME Elizabeth Anderson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-01-8781		17. INFORMANT (Sister) Mrs. Emma Waters, 6200 Elliott St. Balto.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES				Pulmonary Edema ?			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Acute Myocardial Infarction ?			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work Not White At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-20-1967 to 6-21-1967, that (I) (we) last saw the deceased alive on 6-21-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. I. Anderson				23B. DATE SIGNED 6-21-67			
23C. PHYSICIAN'S NAME (Type) Dr. I. Anderson				23D. ADDRESS M.D. Church Home & Hospital, Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/24/67		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 23 1967		25B. NAME OF REGISTRAR Robert E. Kelly, Jr.		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS	

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M.D.

Check for \$100.00  
M. W. [unclear] 12-25-64

M.D.

Elizabeth Anderson

Henry Clark

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12-25-64

Dr. Anderson  
12-25-64

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 6055	
BIRTH NO. 67 6055		CERTIFICATE OF DEATH								Registered No. 67 6055	
1. NAME OF DECEASED (Type or Print) NEVER KELLMAN						2. DATE AND HOUR OF DEATH JUNE 20, 1967 10:35 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 6003 UPDALE COURT					
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH JAN. 16, 1909		9. AGE (In years lost birthday) 58		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR				10B. KIND OF BUSINESS OR INDUSTRY TAXI CAB				11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME AARON J. KELLMAN						14. MOTHER'S MAIDEN NAME RICA H. ROSENSTEIN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. 11 AIR FORCE 216-03-9469				16. SOCIAL SECURITY NO. 216-03-9469		17. INFORMANT ADDRESS MRS. VALERIE KELLMAN, 6003 UPDALE COURT #7					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. OBESITY + HYPERTENSION						CAUSE OF DEATH (A) DUE TO MYOCARDIAL INFARCTION (B) DUE TO CHRONIC MYOCARDITIS (C) CORONARY ARTERY DISEASE		INTERVAL BETWEEN ONSET AND DEATH NONE 8 MONTHS 7 YEARS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) PARTIAL		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JULY 10 1946 to June 20 1967, that (I) (we) last saw the deceased alive on June 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE Melvin N. Borden M.D.						23B. DATE SIGNED 6/20/67					
23C. PHYSICIAN'S NAME (Type) DR. MELVIN N. BORDEN M.D.						23D. ADDRESS 5000 BALTIMORE NATIONAL PIKE 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/21/67		24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUN 23 1967				25B. NAME OF REGISTRAR Robert E. Feltz				25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REIST., RD.			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-10386</u> <u>67</u> <u>6056</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. <u>67</u> <u>6056</u>	
1. NAME OF DECEASED (Type or Print) <b>BATEMAN, BABY GIRL</b>				2. DATE AND HOUR OF DEATH <b>MAY 27, 1967</b> <b>11:10 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21225</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>904 VICTORY AVE.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>5/26/67</b>	9. AGE (In years lost birthday) <b>--</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	<b>8 54</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTO., MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROBERT F. BATEMAN</b>			14. MOTHER'S MAIDEN NAME <b>VIRGINIA (SCHMIDT) BATEMAN</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>HOSPITAL RECORDS</b>			
18. <b>776 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>PREMATURITY</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				INTERVAL BETWEEN ONSET AND DEATH <b>35 hrs.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MAY 26,</b> 19 <b>67</b> to <b>MAY 27,</b> 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MAY 27,</b> 19 <b>67</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (di) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE <b>Corazon P. Arellano</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5-27-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>CORAZON P. ARELLANO</b>				23D. ADDRESS <b>ST. AGNES HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/21/67</b>		24C. NAME of CEMETERY or CREMATORY <b>CATHEDRAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 23 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. MEARS &amp; SON 805 N. CALVERT ST</b>			

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MAY 27, 1967

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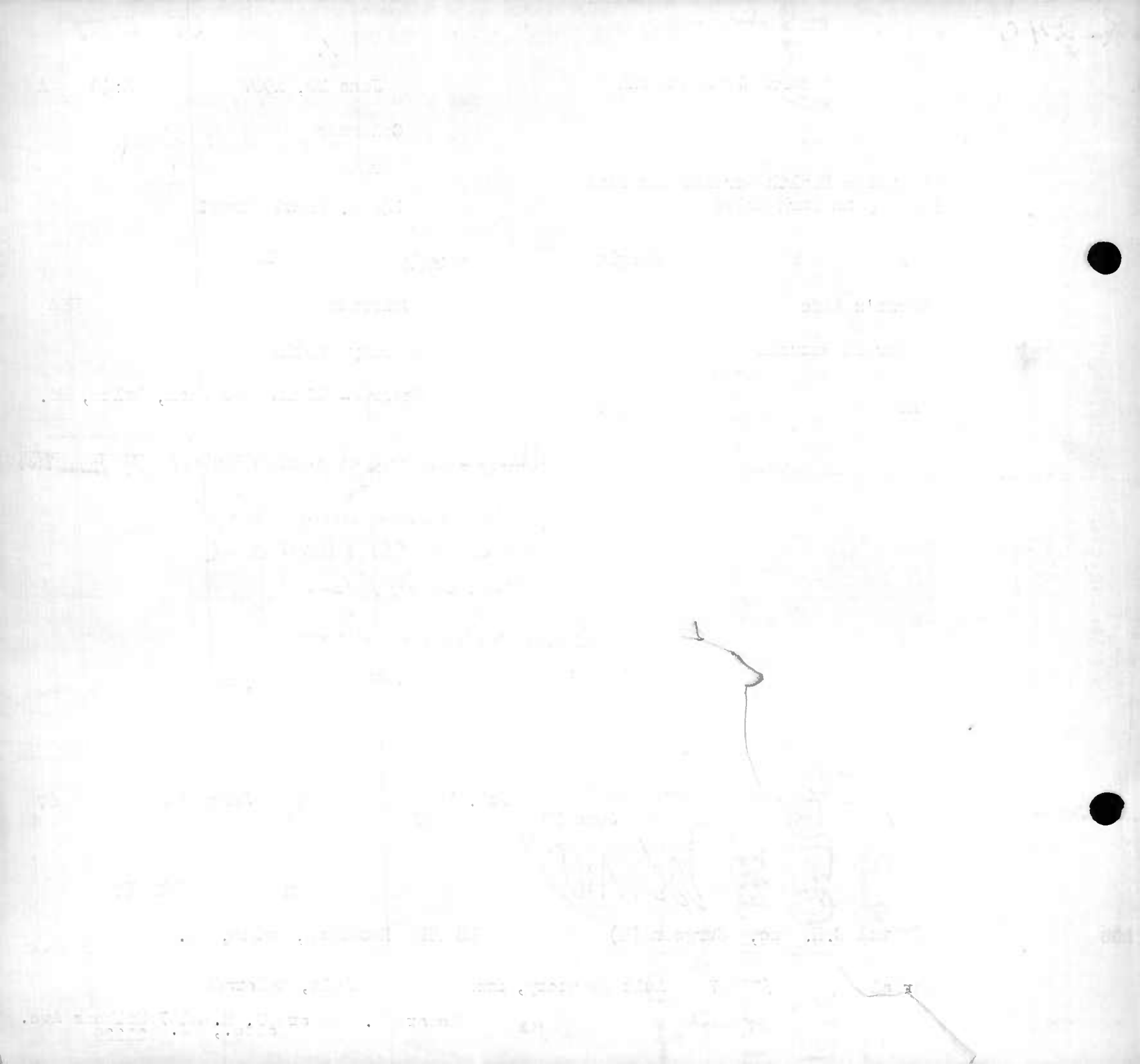
WATSON, ROBERT F.

WATSON, ROBERT F.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 6057		CERTIFICATE OF DEATH				Registered No. 67 6057			
1. NAME OF DECEASED (Type or Print) <b>Carol Jean Russell</b>						2. DATE AND HOUR OF DEATH <b>June 20, 1967</b>   <b>1:40</b> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital 3100 Wyman Park Drive</b>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Colorado</b> B. COUNTY <b>V-05</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Aulto</b> D. STREET ADDRESS (If rural, give location) <b>246 E. First Street</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>		8. DATE OF BIRTH <b>9/29/48</b>	9. AGE (In years last birthday) <b>18</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse's Aide</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harold Russell</b>						14. MOTHER'S MAIDEN NAME <b>Shirley Martin</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>			
18. <b>200.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Bronchopneumonia</b>						CAUSE OF DEATH (A) <b>Malignant lymphoma involving</b> DUE TO (B) <b>mediastinum, lungs, heart,</b> DUE TO (C) <b>Kidneys, chest wall and lymph nodes.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>	
19A. DATE OF OPERATION <b>6/20/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I/this hospital) attended the deceased from <b>Feb. 28</b> 19 <b>67</b> to <b>June 20</b> 19 <b>67</b> , that (I/we) lost saw the deceased alive on <b>June 20</b> 19 <b>67</b> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/We) (did/did not) view the body after death.									
23A. SIGNATURE <b>Samuel C. Lee, M.D.</b>						23B. DATE SIGNED <b>6/20/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>Samuel C.H. Lee, Surgeon (R)</b>						23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/24/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Ault Cemetery, Ault</b>		24D. LOCATION (City, town, or county) (State) <b>Ault, Colorado</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 23 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard F. H.</b>		25D. ADDRESS <b>4107 Wilkens Ave. Balto., Md. 21229</b>			

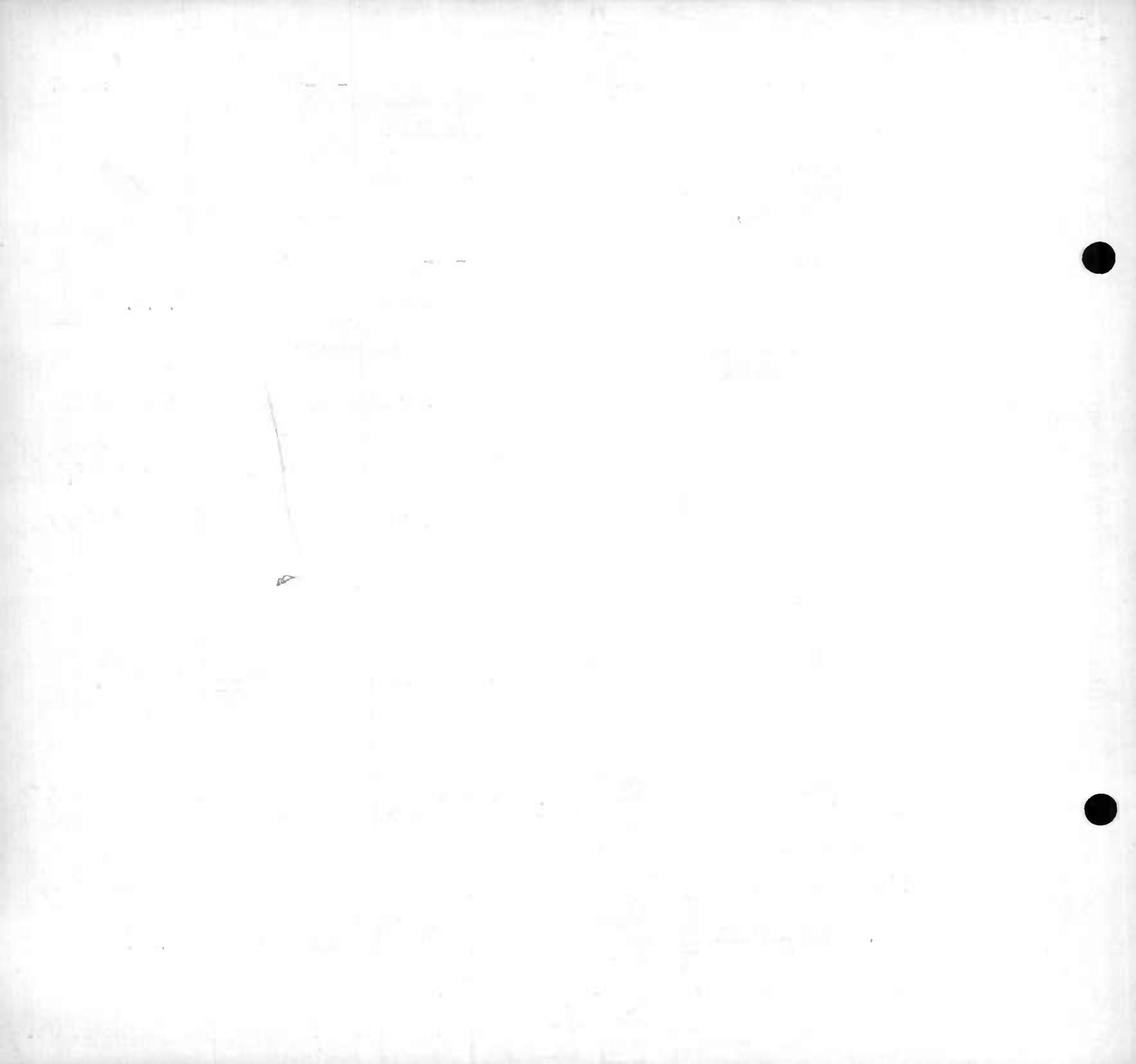




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

43-12-84TN		67 6058		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6058	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>CLARICE LORETTA JOHNSON</b>			
2. DATE AND HOUR OF DEATH <b>6-21-67 11:45 PM M.</b>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 16-02</b> D. STREET ADDRESS (If rural, give location) <b>1015 WHATCOAT STREET 21217</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9-29-29</b>	9. AGE (In years last birthday) <b>37</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WESTLEY COOK</b>				14. MOTHER'S MAIDEN NAME <b>PAULINE PARKER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMATION ADDRESS <b>BCH:RECORDS 4940 EASTERN AVENUE 21224</b>			
18. <b>463-XI</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>recurrent pulmonary embolism</b> DUE TO (B) <b>congestive heart failure</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>years 5 hours 5</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>6/20/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>recurrent pul. embolism</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>5/30</b> 19 <b>67</b> to <b>6/21</b> 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>6/21</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>David Swimmer</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>6/21/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>DR. DAVID SWIMMER</b> M.D.				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO. MD. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-26-67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat'l. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 23 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Nelson Funeral Home 1348 Calhoun St.</b>			



M. 620

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. <u>67 6059</u>		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. <u>67 6059</u>	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
VALERIE MORRIS		June 21, 1967 6:35 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 1009 N. Calhoun Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	Negro	never married	10-2-61
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
5		Md.	U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Morris		Mary Ball	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		none	John Morris 1116 Mosher St.
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
(A) Cerebrocranial injuries			
DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
2			Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, steel, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
		street	1000 Block Carey Street
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	16-02 Pedestrian struck by car
6-21-67 4:30 P.m.			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED		June 22, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	23C. NAME of CEMETERY or CREMATORY
Burial		6-24-67	Mt. Auburn Cem.
23D. LOCATION (City, town, or county) (State)		Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
JUN 23 1967		Robert E. Farber, M.D.	Kelson Funeral Home 1348 Calhoun St.

WILHELM KUNIG

FUNERAL DIRECTOR: IMPORTANT

This must be approved by the chief medical examiner or his assistant if death occurred in a hospital and as released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6060</b>	
BIRTH NO. <b>67 6060</b>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>PHILLIP McGuire</b>			2. DATE AND HOUR OF DEATH <b>6-17-67</b> <b>8 40</b> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>X</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>800 Bethune Road</b>		
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Child</b>	8. DATE OF BIRTH <b>11/2/59</b>	9. AGE (In years lost birthday) <b>7</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Bernard Conaway</b>			14. MOTHER'S MAIDEN NAME <b>Cynthia McGuire</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs Cynthia Saunders 800 Bethune Rd</b>		
18. <b>3355 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>INTRACRANIAL LESION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>UNKNOWN ONSET</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6-17-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JUNE 19, 19 67</b> to <b>JUNE 17, 19 67</b> , that (I) (we) last saw the deceased alive on <b>JUNE 17, 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harold A. Burnham</b> M.D.				23B. DATE SIGNED <b>6-17-67</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/21/67</b>	24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 23 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Sanders</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Adolphus Halstead 1206 W North Ave</b>	

7 22 4

6-17-07

Project 24 6 10 2

2-10-07

INTER-COMMUNITY

2-10-07

2-10-07

2-10-07

2-10-07

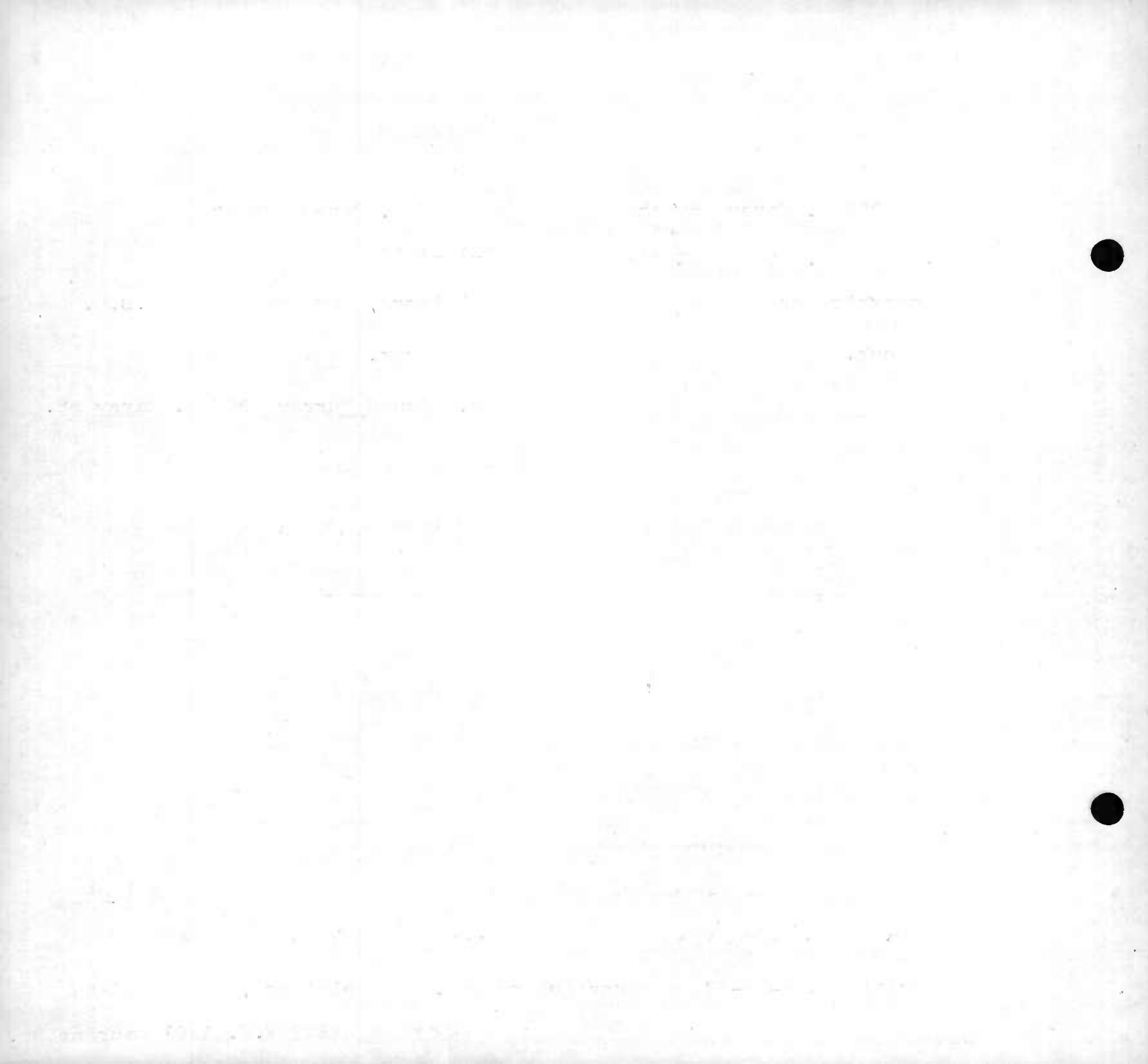
7

Handwritten signature

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6061				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6061	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BERTHA CHEW							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
908 N. Carey Street				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
D. STREET ADDRESS (If rural, give location)				908 N. Carey Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
F.	N.	SINGLE	2-12-1910	57			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Domestic Work			Baltimore, Maryland		U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
unk.				unk.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS		
			Mr. Edmund Murray		908 N. Carey St.		
18. 444X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		5+y	
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
0	6	0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
10							
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?					
	While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from 19 60 to June 16 19 67, that (I) (we) last saw the deceased alive on June 16 19 67 and that (I) (my) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Kingston						6/21/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
G. D. Kingston		845 Harlem Ave. Bklyn. 21201					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)		(State)		
Burial	6-23-67	Mount Auburn Cem.	Baltimore,		Maryland		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS			
JUN 23 1967	Robert E. Galt	MORTON & DYETT F.H.		1701 Laurens St.			





BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED  
(Type or Print)

HAZEL LANIER

2. DATE AND HOUR PRONOUNCED DEAD

June 21, 1967

2:55 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street  
address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

815 Bethune Road

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

10-22-1923

9. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Morven, North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Albert Moore

14. MOTHER'S MAIDEN NAME

Cora Bradley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Robert Moore

3706 Harlem Ave

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) ~~XXXX~~

Intracerebral hemorrhage

(origin in left thalamus)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
m. WORK AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 22, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6-23-67

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cem. Balto.

23D. LOCATION

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 23 1967

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Morton E. Dyett F.H.

ADDRESS

1701 Laurens St.

Domestic  
P/sect  
Office

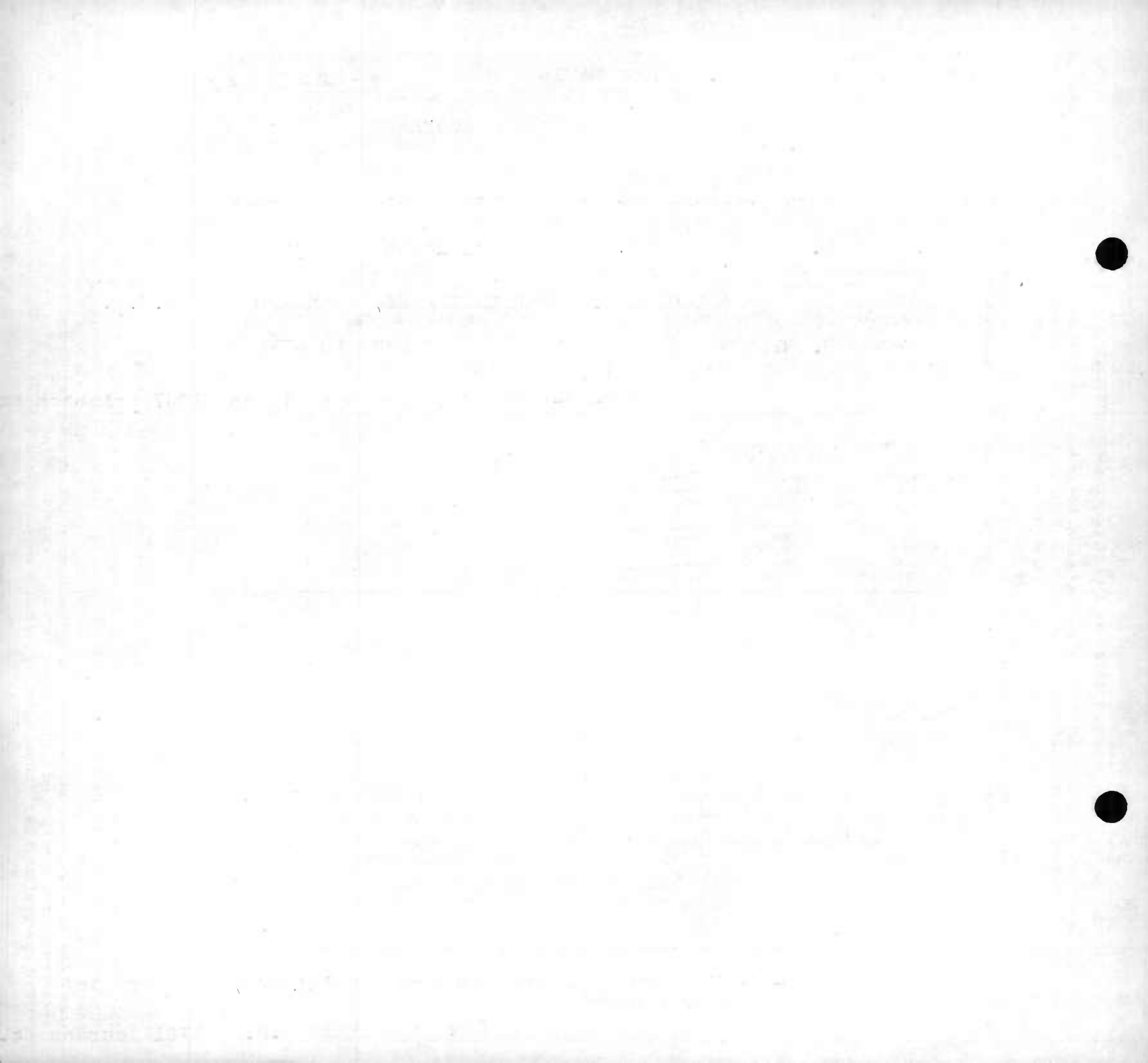
Domestic  
P/sect  
Office

Domestic  
P/sect  
Office

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

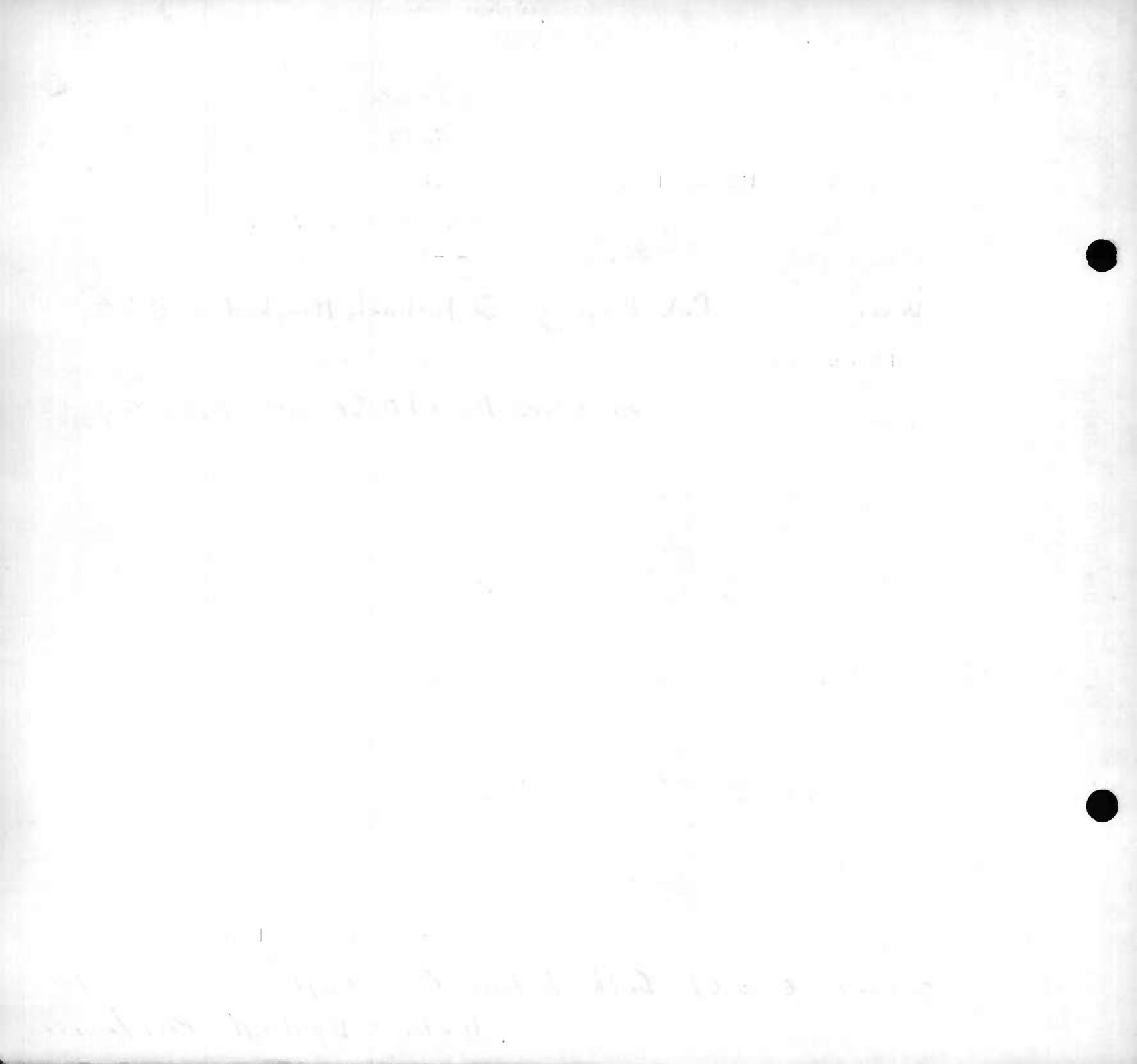
BALTIMORE CITY HEALTH DEPARTMENT									
67 6063					Registered No. 67 6063				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
DORIS S. WILSON DAVIS					6-22-67				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION					A. STATE B. COUNTY				
(If not in hospital or institution, give street address or location)					MARYLAND				
3047 Brighton Street					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					BALTIMORE				
D. STREET ADDRESS (If rural, give location)					3047 Brighton Street				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
F.	N.	WIDOWED, DIVORCED (specify) SEPARATED	6-8-1925	42	COOK	DOUBLE T. DINER	BALTIMORE, MARYLAND	U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
EDWARD H. WILSON					PEARLENA PULLIAM				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
					220-14-6566				
17. INFORMANT					ADDRESS				
					Mrs. Pearlana Wilson 3047 Brighton St				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO				
ANTECEDENT CAUSES					(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) DUE TO				
II					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from June 16, 1967 to June 22, 1967, that (I) (we) last saw the deceased alive on June 22, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
JEDDY.MD					6-22-67				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
JEDDY.MD					549 N. Fullon Ave				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)	
BURIAL			6-26-67		Mount Auburn Cemetery			Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
JUN 23 1967			Robert E. Jedd			MORTON & DYETT F.H. 1701 Laurens St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6064</b>	
BIRTH NO. <b>67 6064</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <b>1</b>			2. DATE AND HOUR OF DEATH <b>6/21/67 4:15 A.M.</b>		
1. NAME OF DECEASED (Type or Print) <b>GROSS, ROBERT</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>10-01</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1114 SOMERSET STREET</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SEPARATED</b>	8. DATE OF BIRTH <b>4-1-12</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Cab Company</b>	11. BIRTHPLACE (State or foreign country) <b>St. Michaels, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>RICHARD GROSS</b>			14. MOTHER'S MAIDEN NAME <b>SUSAN BUTLER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-07-2855</b>	17. INFORMANT <b>Mrs. Edith Skinner 1915 N. Payson St.</b>		
18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Metastatic Ca Esophagus</b> DUE TO (B) DUE TO (C) 		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>3/15/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca Esophagus</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>1/24</b> 19 <b>67</b> to <b>6/21</b> 19 <b>67</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>6/21</b> 19 <b>67</b> and that in (my) <b>(aur)</b> opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Melvin H. Epstein</b> M.D.				23B. DATE SIGNED <b>6/21/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>MELVIN H. EPSTEIN</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>6-26-67</b>	24C. NAME of CEMETERY or CREMATORY <b>Balto. National Cem. Balto.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 23 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Sander</b>		25C. FUNERAL DIRECTOR <b>Morton E. Dyett F.H.</b>	
				ADDRESS <b>1701 Laurens</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6065				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6065	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>CARRIE Bigham</i>		2. DATE AND HOUR OF DEATH <i>6/21/67 7 p. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE <i>MARYLAND</i> B. COUNTY <i>W. Fayette St.</i>			
<i>1943 W Fayette St. Baltimore 21223</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 2001</i>			
D. STREET ADDRESS (If rural, give location) <i>1943 W. Fayette St</i>							
5. SEX <i>F.</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>12-19-1895</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Cape Charles Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>212-26-693</i>		17. INFORMANT <i>Mrs. M. Ellis - 1943 W. Fayette St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Arteriosclerosis Heart disease</i> DUE TO <i>with Heart Block and</i> (B) <i>congestive Heart failure</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>at least 2 yrs -</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4/12 1967</i> to <i>6/21 1967</i> , that (I) (we) last saw the deceased alive on <i>6/15 1967</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Elijah Saunders</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6-22-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>ELIJAH SAUNDERS</i>				23D. ADDRESS <i>3414 Duwall Ave. Balt, md 21216</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>JUN 23 1967</i>		24C. NAME of CEMETERY or CREMATORY <i>Pleasant Shade Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Hampton Va</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Saunders</i>		25C. FUNERAL DIRECTOR <i>Cooper Memorial Chapel - 512 N. Carrollton Ave</i>		ADDRESS <i>J. L. Rios</i>	

Active 2

F. (Gordon) Williams

12-14-1975 21

Capt Charles D. Williams

2-12-71 1975-1976 M. Ellis - 1976 W. Williams

1975-1976

Planned to be (Gordon) Williams  
1975-1976 21-12-1975 21  
1975-1976 21-12-1975 21



1  
D-340

67 6066

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6066

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **CECIL J. DUDLEY** 2. DATE AND HOUR PRONOUNCED DEAD **June 20, 1967 4:10 P. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

**1723 St. Paul Street** **1723 St. Paul Street**

5. SEX **Male** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Divorced** 8. DATE OF BIRTH **Sept. 19, 1910** 9. AGE (In years last birthday) **56** 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Painter** 11. BIRTHPLACE (State or foreign country) **Virginia** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Edward Dudley** 14. MOTHER'S MAIDEN NAME **Daisey Jewell**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **Yes W.W.II** 16. SOCIAL SECURITY NO. **226-01-8752** 17. INFORMANT **Clifford Dudley** ADDRESS **1927 Jefferson Dr. Alexandria**

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH **Arteriosclerotic Cardiovascular Disease**

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Werner U. Spitz, M.D.** CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **6/21/67**

EXAMINER'S NAME (Type) **Werner U. Spitz, M.D.** ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **6/23/67** 23C. NAME of CEMETERY or CREMATORY **Baltimore National Cem.** 23D. LOCATION (City, town, or county) (State) **Baltimore, md.**

24A. DATE REC'D BY HEALTH DEPT. **JUN 23 1967** 24B. NAME OF REGISTRAR **Robert E. ...** 24C. FUNERAL DIRECTOR **Wm. Cook-Brooks, Inc.** ADDRESS **1217 St. Paul St.**

VS 151-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 6067		REGISTERED NO. 67 6067	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <u>William Harry Smith</u>				2. DATE AND HOUR OF DEATH <u>June 21 1967 9:25 A.</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>9-03</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>602 Venable Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>1/20/29</u>	9. AGE (In years & months) <u>37</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Cement Finisher</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas Smith</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Marshall</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-12-8240</u>		17. INFORMANT <u>Mrs Sara R. Smith</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>BRONCHO PNEUMONIA</u>				ADDRESS <u>602 Venable Ave</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO (C) <u>AB. J. J. J.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>BRONCHOGENIC CARCINOMA</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>44</u> (this hospital) attended the deceased from <u>6/17/67</u> 19 <u>67</u> to <u>6/21</u> 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>6/21</u> 19 <u>67</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death.							
23A. SIGNATURE <u>Nat E. Watson, Jr.</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/21/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>NAT E. WATSON, JR.</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>6/24/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount crematory</u>		24D. LOCATION (City, town, or county) (State) <u>Balto, Md. 21202</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 23 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. J. J.</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc. 1217 St. Paul St.</u>			

June 21, 1967

William Henry Davis

John Memorial Hospital  
Male Cancer  
11/2/67

James - th

Mr. Davis R. Smith

Yes

11/2/67  
11/2/67  
11/2/67  
11/2/67

11/2/67  
11/2/67  
11/2/67  
11/2/67

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.5em;">67 6068</span>	
BIRTH NO.				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">PAPPAS, CATHERINE ANN</span>				22 June 67 11:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">UNION MEMORIAL HOSP.</span>		(If not in hospital or institution, give street address or location)		A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span>	
				D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">3104 ABELL AVE.</span>	
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">W</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">07-23-89</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">77</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">TURKEY</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">MICHAEL KAZAN</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">CATHERINE NEEDLE</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">unk</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">unk</span>		17. INFORMANT ADDRESS
18. <span style="font-size: 1.2em;">420.11</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">PULMONARY EDEMA</span>			CAUSE OF DEATH (A) DUE TO <span style="font-size: 1.2em;">ACUTE MYOCARDIAL INFARCTION</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO <span style="font-size: 1.2em;">ABN</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) <span style="font-size: 1.2em;">HYPERTENSIVE ARTERIO SCLEROTIC HEART DISEASE</span>		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">9 MAY</span> 19 <span style="font-size: 1.2em;">67</span> to <span style="font-size: 1.2em;">22 JUNE</span> 19 <span style="font-size: 1.2em;">67</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">22 JUNE</span> 19 <span style="font-size: 1.2em;">67</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Sidney E. Kirdley</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">22 June 67</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">M.D.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">6/26/67</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Greek Orthodox Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Co., Md.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 23 1967</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Wm. Cook-Brooks, Inc.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">1217 St. Paul St.</span>	

PRIMARY EDEMA

ACUTE MYOCARDIAL INFARCTION

*Handwritten signature*

HEARTENAL RESPIRATORY NERVE DISEASE

49-30-66

FR

67 6069

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 6069

BIRTH NO.

M.E. CASE NO.

I. NAME OF DECEASED

(Type or Print)

John J. Quinn

2. DATE AND HOUR OF DEATH

June 20, 1967

12:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

48 Market Place

21201

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

3-29-1911

9. AGE (In years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William J. Quinn

14. MOTHER'S MAIDEN NAME

Mary McAleer

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

216-03-7283

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

HYPOXIA

(A) DUE TO shock, aspiration

(B) DUE TO CARCINOMA FLOR of mouth

(C) DUE TO occlusion Bil. PTB.

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

June 14, 1967

WAS PERFORMED

NO

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notly medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At  
Work ☐Not White  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 19, 1967 to June 20, 1967,  
that (I) (we) last saw the deceased alive on June 20, 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Carlos D. Faustino

M.D.

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

June 20, 1967

23C. PHYSICIAN'S  
NAME (Type)

Carlos D. Faustino

M.D.

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

6-23-67

24C. NAME of CEMETERY or CREMATORY

New Catholic Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUN 23 1967

25B. NAME OF REGISTRAR

Robert E. Gable

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks Inc. 1217 St. Paul St.

Balti. Maryland

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

519-03-2583

No



K 320

67 6070

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6070

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARY KUTCH

2. DATE AND HOUR PRONOUNCED DEAD

June 18, 1967 7:55 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1650 Bentalou Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 21, 1922

9. AGE (In years lost birthday)

45 44

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Geo. W. Lee

14. MOTHER'S MAIDEN NAME

Lillian Woods

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-20-3394

17. INFORMANT

ADDRESS

Grace Britt - 2317 Cunnah Ave

18. 2816.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Laceration of spleen with hemoperitoneum  
DUE TO

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Fort Smallwood Road

150 ft. south of Baltimore City Line

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

6-18-67 4:43 A.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 18, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

June 23, 1967

23C. NAME of CEMETERY or CREMATORY

Baltimore National - Baltimore, Md

23D. LOCATION

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 23 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Edgar L. Lynch - 2463 Druid Hill Ave - 17

ADDRESS

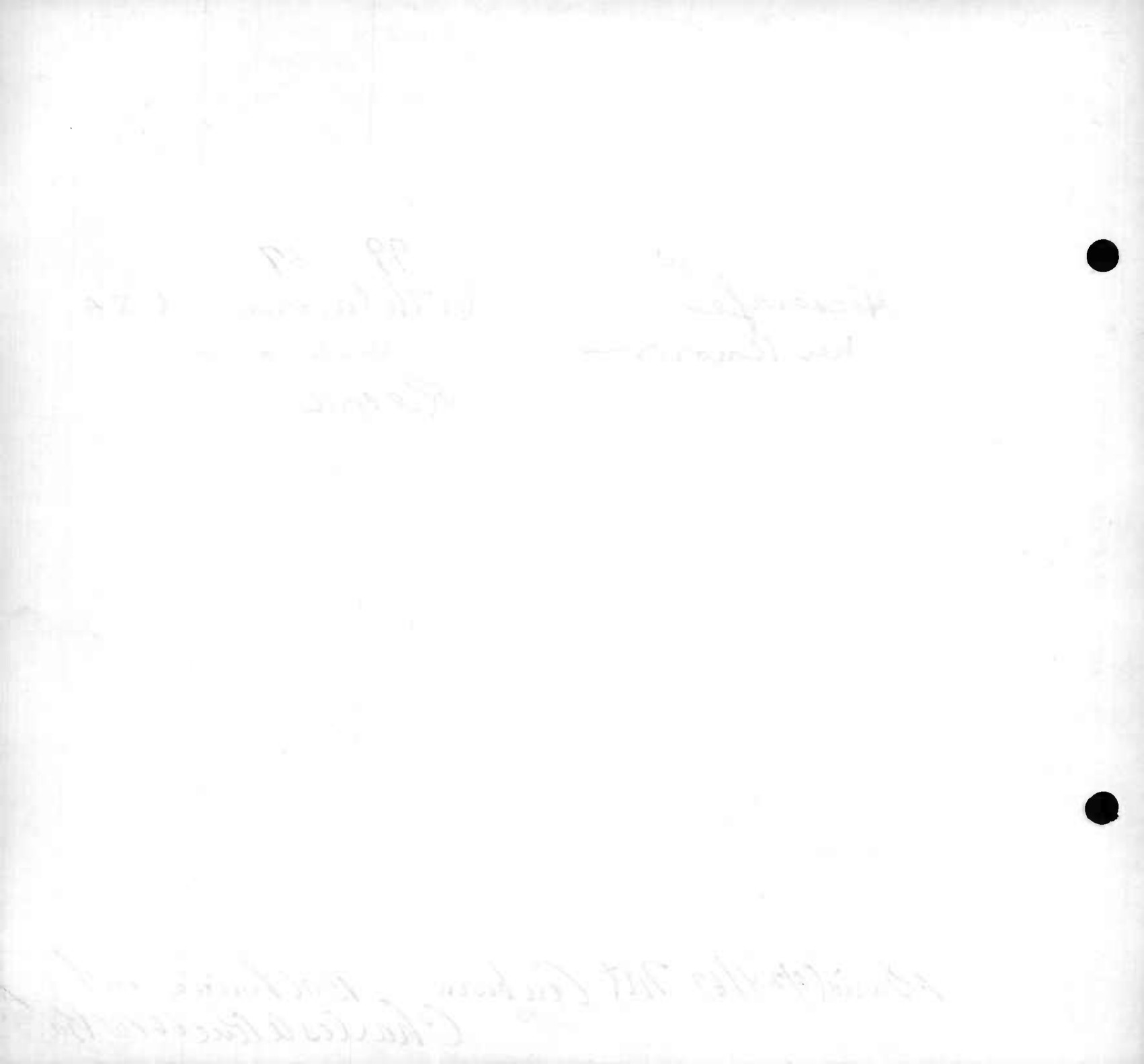
11/1/77



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 67 6071	
BIRTH NO. 67 6071		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CHERRY, MARY</b>		2. DATE AND HOUR OF DEATH <b>6-21-67 1235 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>				A. STATE <b>BALTIMORE</b> B. COUNTY <b>MARYLAND</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>X</b>			
				D. STREET ADDRESS (If rural, give location) <b>914 Coppin Ct 25-32</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>12-6-98</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records</b>		ADDRESS	
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CHRONIC RENAL FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HTCVD</b>				CAUSE OF DEATH (A) <b>CHRONIC RENAL FAILURE</b> DUE TO (B) <b>HTCVD</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>undetermined</b> <b>10+ years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>GASTROINTESTINAL HEMMORHAGE</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5-27-1967</b> to <b>6-21-1967</b> , that (I) (we) last saw the deceased alive on <b>6-21-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-21-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>				23D. ADDRESS <b>UNIV. HOSP. BALTIMORE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/24/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) <b>Baltimore md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 23 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rue</b>		ADDRESS <b>661 W. Baw...</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67-1150167 6072		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6072	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>William Michael L Simpson</i>		2. DATE AND HOUR OF DEATH <i>6/17/67 4:40 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>LUTHERAN HOSPITAL</i>		A. STATE <i>MARYLAND</i>		B. COUNTY <i>AD</i>	
5. SEX <i>MALE</i>		6. RACE <i>WHITE</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>SINGLE</i>	
8. DATE OF BIRTH <i>6/16/67</i>		9. AGE (In years last birthday) <i>11</i>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Randy Simpson</i>		14. MOTHER'S MAIDEN NAME <i>Phyllis Patterson</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Nine</i>		17. INFORMANT <i>Randy Simpson - Same</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>773.01</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>11 hours</i>	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) SEVERE RESPIRATORY DISTRESS DUE TO SYNDROME			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/16/67 5:04 PM</i> to <i>6/17 4:40 AM</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6/14/67</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. Speranza</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/17/67</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>LUTHERAN HOSPITAL OF MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-22-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Shepherd's Cemetery</i>	
24D. LOCATION (City, town, or county) <i>HENDERSONVILLE, North Carolina</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 23 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Spadina</i>		25C. FUNERAL DIRECTOR <i>Elsworth Armacost</i>	
				ADDRESS <i>4600 Liberty Heights</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6073	
BIRTH NO. 67 6073				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Helen Harvey</b>			2. DATE AND HOUR OF DEATH <b>6/22/67 2 AM</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Long Green Nursing Home</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>116 West University Parkway</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>7-13-1895</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George C. Buckless</b>			14. MOTHER'S MAIDEN NAME <b>Anna A. Kaiser</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		
17. INFORMANT <b>Ellis A. Newton - Charles &amp; 29th Street</b>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>1538 I</b> <b>CAUSE OF DEATH</b> <b>coronary of colon &amp; intestines</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b>			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>old myocardial infarction</b>					
19A. DATE OF OPERATION <b>see CS</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>cor of colon</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/1/65</b> to <b>6/22/67</b> , that (I) (we) last saw the deceased alive on <b>6/17/67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William D. Jones</b> M.D.			23B. DATE SIGNED <b>6/22/67</b>		
23C. PHYSICIAN'S NAME (Type) <b>William D. Jones</b>			23D. ADDRESS <b>3222 St Paul St Bk Hts</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-24-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 23 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Bailey</b>		25C. FUNERAL DIRECTOR <b>Ellsworth Armacost-4600 Liberty Hghts. Ave</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6074	
BIRTH NO. 67 6074		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Petz Mr. George EDWARD</i>		2. DATE AND HOUR OF DEATH <i>JUNE 22nd, 1967, 08:40AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>16-08</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>3525 Gelston Drive</i>			
5. SEX <i>Male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>9-24-91</i>	9. AGE (In years lost birthday) <i>75</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>R.R. Retirement</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Railway Express Messenger</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>George Petz</i>		14. MOTHER'S MAIDEN NAME <i>Emelia Volkmar</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes W.W.I</i>		16. SOCIAL SECURITY NO. <i>714-05-6709</i>		17. INFORMANT <i>Karl V. Petz 208 Westshire Rd. (29)</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Competitive heart failure</i> DUE TO (B) <i>Arterioscler. cardiovascular disease</i> (C) <i>Old post. myocardial infarct</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Bicus. valvulopathy</i>					
19A. DATE OF OPERATION <i>6/20</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <i>this hospital</i> ) attended the deceased from <i>6/20</i> 19 <i>67</i> to <i>6/22</i> 19 <i>67</i> , that (I) ( <i>we</i> ) last saw the deceased alive on <i>6/22</i> 19 <i>67</i> and that in (my) ( <i>our</i> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <i>we</i> ) ( <i>did</i> ) (did not) view the body after death.					
23A. SIGNATURE <i>S. R. Jank</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/22/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>SAH ROX PARK</i>		23D. ADDRESS <i>Bon Secours Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-26-1967</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National</i>	
24D. LOCATION <i>Baltimore</i>		24E. (City, town, or county)		24F. (State) <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 23 1967</i>		25B. NAME OF REGISTRAR <i>R. E. E. E.</i>		25C. FUNERAL DIRECTOR <i>Howard Stroy 307 W. North Ave</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6075		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6075	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) SEOHNLEIN, WILBERT L.			2. DATE AND HOUR OF DEATH 6-22-67 11:30 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
5. SEX M			6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M
8. DATE OF BIRTH 5-19-04		9. AGE (In years last birthday) 62		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Runner			10B. KIND OF BUSINESS OR INDUSTRY 1st. National Bank Baltimore, Maryland		
13. FATHER'S NAME Mother's Catherine Plitt			14. MOTHER'S MAIDEN NAME Father's Frank Seohnlein		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. Unknown		
17. INFORMANT Mrs. Margaret E. Seohnlein			ADDRESS Pratt Pk 3412 E. Pratt		
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating UNDERLYING CONDITION last.			(A) GENERALIZED CARDIOVASC. COLLAPSE DUE TO ARTERIOSCLEROTIC HEART DISEASE		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(B) <del>POSSIBLE ANAPHYLACTIC REACTION</del>		
19A. DATE OF OPERATION 6-21-67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TIC DOLOREUX		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (this hospital) attended the deceased from 6-17-1967 to 6-22-1967, that (we) lost saw the deceased alive on 6-22-1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE William T. Mason			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-23-67
23C. PHYSICIAN'S NAME (Type) William T. Mason			23D. ADDRESS MERCY HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/67		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224		25A. DATE REC'D BY HEALTH DEPT. JUN 23 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St			

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BIRTH NO.

67 6076

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 6076

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JULIAN O. HANSON

2. DATE AND HOUR PRONOUNCED DEAD

June 18, 1967

2:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3501 Flannery Lane

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

8/15/64

9. AGE (In years  
last birthday)

2

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frank L. Hanson

14. MOTHER'S MAIDEN NAME

Rosa Edmunds

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Frank L. Hanson 3501 Flannery Lane

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Bilateral acute bronchopneumonia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 18, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/21/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

(State)

3501 Frederick Ave (Baltimore)

24A. DATE REC'D BY HEALTH DEPT.

JUN 23 1967

24B. NAME OF REGISTRAR

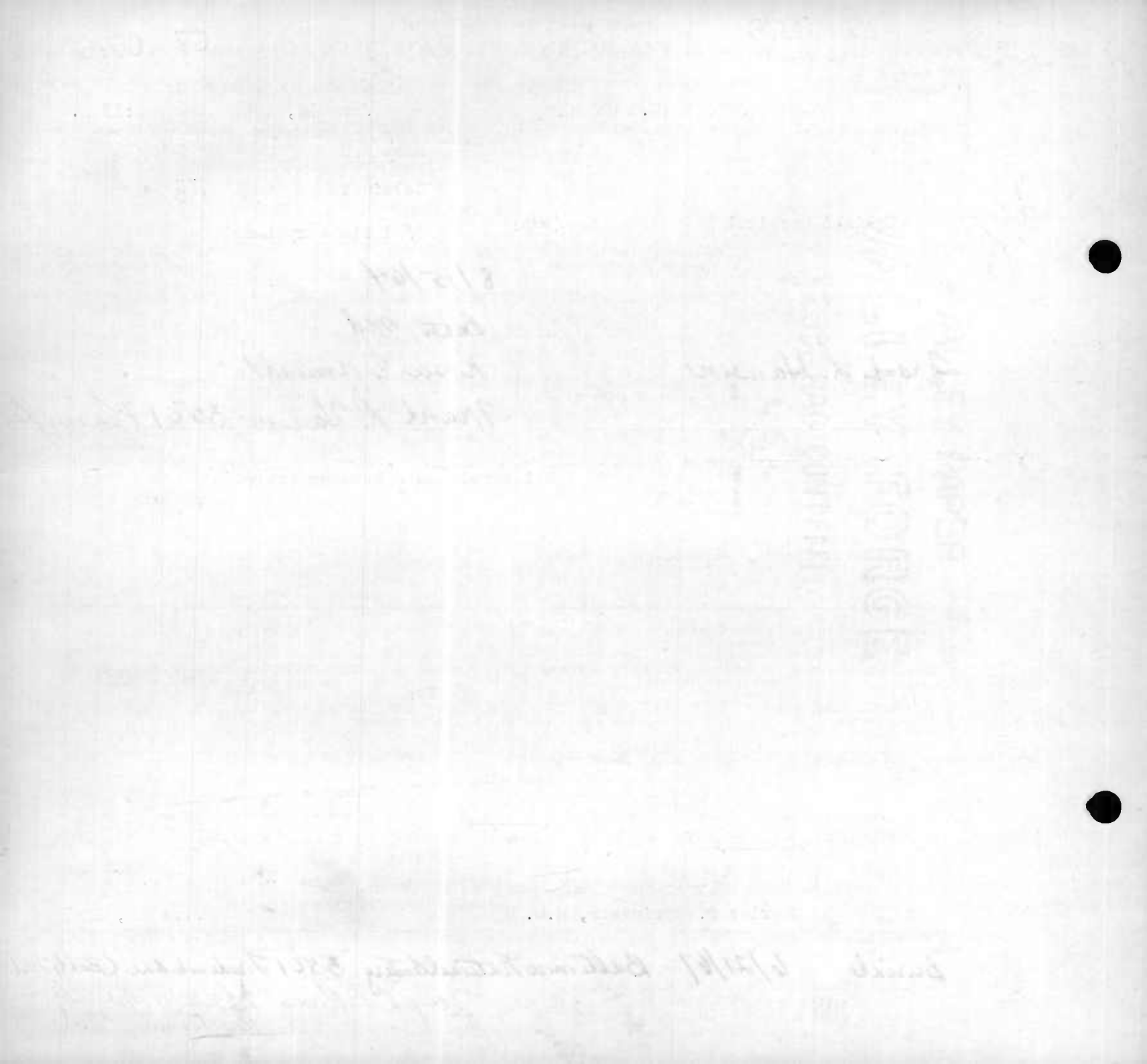
Robert E. Fickens

24C. FUNERAL DIRECTOR

Joseph L. Rues

ADDRESS

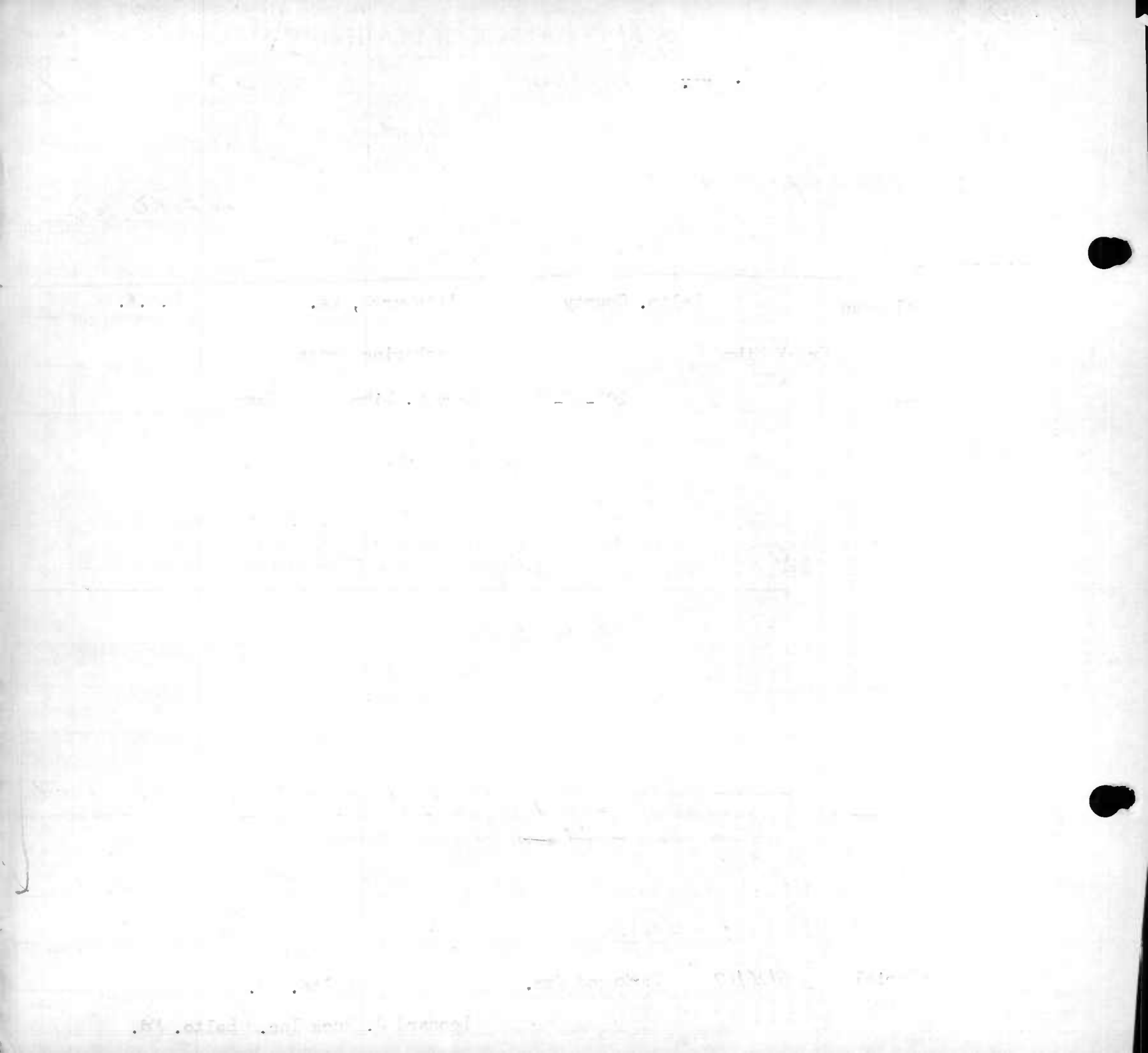
2222 W. North Ave.  
Baltimore, Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department									
67 6077 CERTIFICATE OF DEATH					Registered No. 67 6077				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>Louis J. Mihm</i>					2. DATE AND HOUR OF DEATH <i>6-21-67</i> <i>8:50 P.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>MERCY HOSPITAL</i>					A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTO</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> <i>5300</i>				
					D. STREET ADDRESS (If rural, give location) <i>8751 OLD HANFORD RD</i>				
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>1-8-05</i>	9. AGE (In years lost birthday) <i>62</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Balto. County</i>		11. BIRTHPLACE (State or foreign country) <i>Pittsburgh, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Frank Mihm</i>					14. MOTHER'S MAIDEN NAME <i>Catherine Gross</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>208-03-6342</i>		17. INFORMANT <i>Mary M. Mihm</i>		ADDRESS <i>Same</i>		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Acute Renal Failure</i>					CAUSE OF DEATH (A) <i>Acute Myocardial Infarction</i> DUE TO (B) <i>Previous Myocardial Infarction</i> DUE TO <i>Atherosclerotic + Possibly</i> (C) <i>Rheumatic Heart Disease</i>			INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>6</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>(NO)</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>6-17</i> 19 <i>67</i> to <i>6-21</i> 19 <i>67</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>6-21</i> 19 <i>67</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <i>Michael A. Ellis</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/24/67</i>		
23C. PHYSICIAN'S NAME (Type) <i>Michael A. Ellis</i>					23D. ADDRESS <i>Mercy Hosp Balto Md.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/26/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 23 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. Fiedler</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md.</i>				

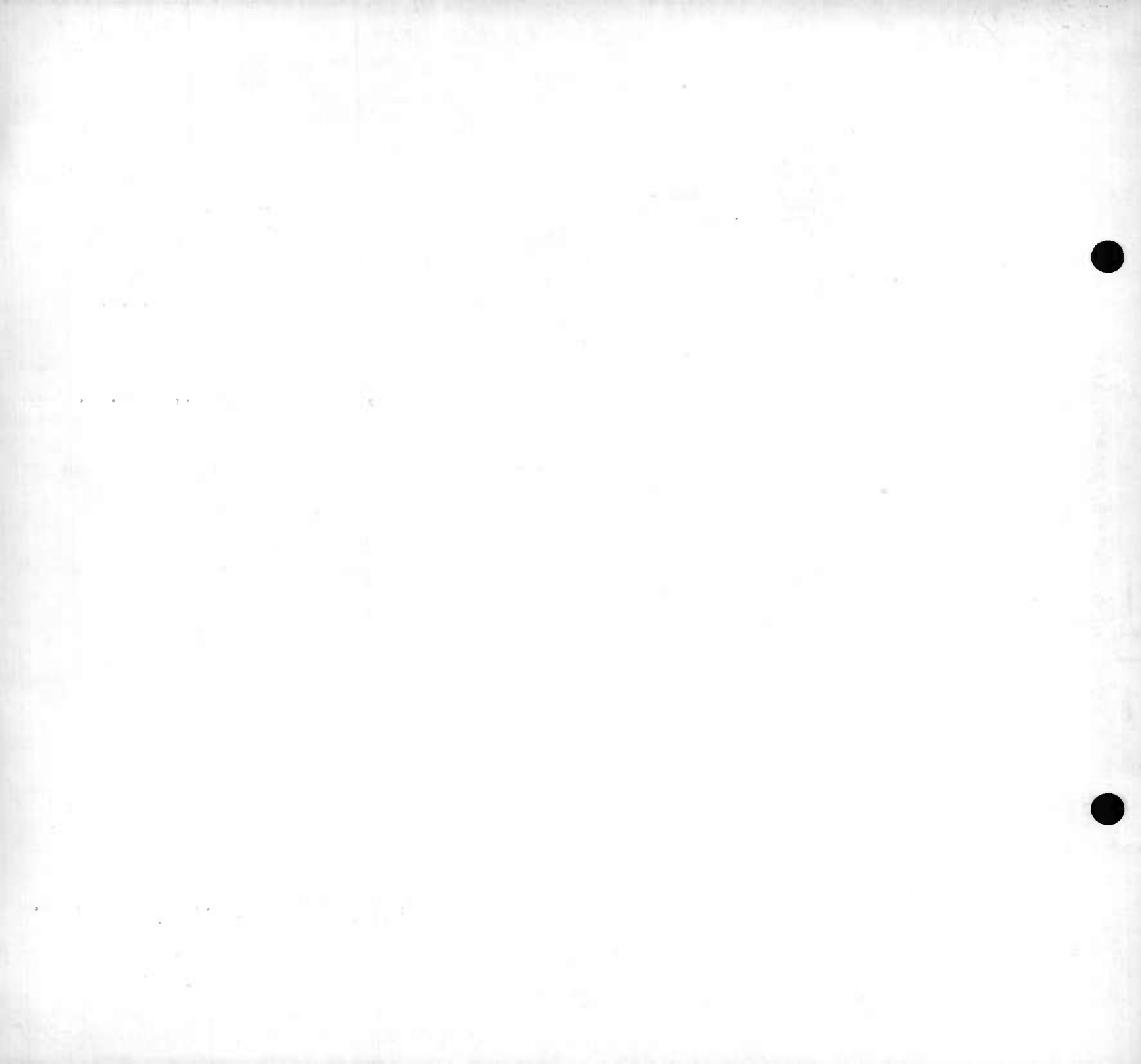




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

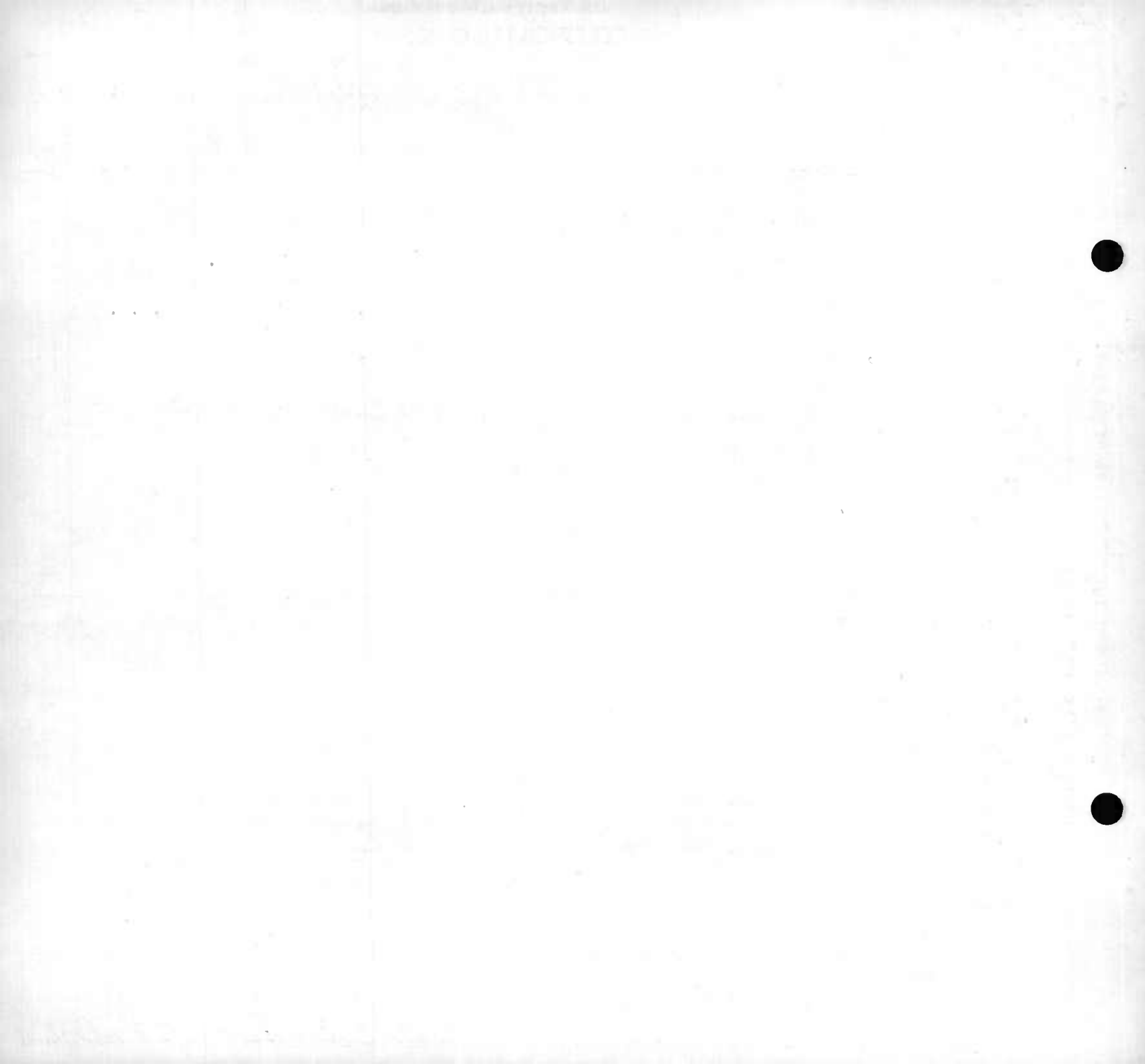
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6078</u>	
BIRTH NO. <u>67 6078</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>1-631</u>		1. NAME OF DECEASED (Type or Print) <u>HOWARD E. CARTER</u>		2. DATE AND HOUR OF DEATH <u>6/20</u> <u>955</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND 21224</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1830 BOLTON STREET - 21217</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SEPARATED</u>	8. DATE OF BIRTH <u>5/9/90</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>BABE CARTER</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224</u>	
18. <u>20431</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>ACUTE LEUKEMIA</u> DUE TO (B) <u>ARTERIOSCLEROTIC</u> DUE TO <u>CARDIOVASCULAR</u> DISEASE (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>  <u>30 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/29</u> 19 <u>67</u> to <u>6/20</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/20</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ian Shenk</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6/20/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>IAN SHENK</u>		23D. ADDRESS <u>BCH, 4940 Eastern Ave., Baltimore, Md.</u> <u>550 N. BROADWAY</u> <u>BALTO., MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>June 23/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>a.a. County Md.</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Milton E. Elickson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>1129 N. Caroline St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6079</b>	
BIRTH NO. <b>67 6079</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ANNA THORNTON</b>		2. DATE AND HOUR OF DEATH <b>6/21/67 10:45 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b> <b>601 North Broadway</b> <b>Baltimore, Maryland 21205</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>1801 Duncan Street</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7/6/18</b>	9. AGE (In years last birthday) <b>48 yrs.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baby-sitter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Hitch, Columbus</b>		14. MOTHER'S MAIDEN NAME <b>Walters, Mazzie</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mary Franklin 1627 Gay St</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Cardiac arrest</b> DUE TO (B) <b>Subarachnoid Hemorrhage</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/16</b> 19 <b>67</b> to <b>6/21</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/21</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Kenneth L. Brigham</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/21/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>KENNETH L. BRIGHAM</b>		23D. ADDRESS M.D. <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 24/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mr Culinary Cove</b>	
24D. LOCATION (City, town, or county) (State) <b>A.A. County Md</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>Milton E. Elukhion</b>		25C. FUNERAL DIRECTOR <b>1129 N. Calvert</b>			



40-35-35-35 DH 15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6080				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6080	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>IDA MARIE JORDAN</b>		2. DATE AND HOUR OF DEATH <b>6-21-67</b> <b>5 P.</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4940 Eastern Avenue #21224</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b> <b>Single</b>	8. DATE OF BIRTH <b>9-14-46</b>	9. AGE (In years last birthday) <b>20</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Fairley Jordan</b>				14. MOTHER'S MAIDEN NAME <b>Ida Mae Little</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>BCH</b> <b>4940 Eastern Avenue</b> <b>RECORDS:</b> <b>Baltimore, Maryland #21224</b>			
18. <b>793X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Pneumonia</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>2d</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Congenital Brain Anomaly - epilepsy, retarded</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>he</del> (this hospital) attended the deceased from <b>5-27</b> 19 <b>64</b> to <b>6-21</b> 19 <b>67</b> , that <del>it</del> (we) lost saw the deceased alive on <b>6-21</b> 19 <b>67</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) (did not) view the body after death.							
23A. SIGNATURE <b>James T. Corkins</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-21-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>James T. Corkins</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Md. #21224</b>			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <b>June 23/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenwood</b>		24D. LOCATION (City, town, or county) (State) <b>Wheaton, N. C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 23 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Milton E. Erickson</b> ADDRESS <b>1129 N. Carroll St</b>			

12th Avenue, Brooklyn, N.Y. 11219

0-21-07

4-2-74

24

Permanence

Original from Bureau of Census

10-15-07 04-02-07 10-15-07

James J. Corbin

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>67 6081</u>	
BIRTH NO. <u>67 6081</u>		CERTIFICATE OF DEATH									
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <u>Sterling E. Elbeck</u>						2. DATE AND HOUR OF DEATH <u>June 21, 1967</u> <u>2:20 p.m.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>					
						D. STREET ADDRESS (If rural, give location) <u>535 W. Lafayette Avenue</u>					
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>March 2, 1914</u>		9. AGE (In years last birthday) <u>53</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Willie Elbeck</u>						14. MOTHER'S MAIDEN NAME <u>Beulah ?</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>244-09-9386</u>		17. INFORMANT <u>Alice Elbeck-wife</u>		ADDRESS <u>same</u>			
18. <u>43411</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Edema</u> ANTECEDENT CAUSES <u>Congestive Heart Failure</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertension</u>						CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>June 21, 1967</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>no</u>		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>June 5, 1967</u> to <u>June 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 21, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>LIZARAZO</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>June 21, 1967</u>			
23C. PHYSICIAN'S NAME (Type) <u>Lizarazo</u>						M.D. 23D. ADDRESS <u>1514 Division Street-Baltimore, Maryland</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>June 24 1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>My Auburn Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Westport Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 23 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>		25C. FUNERAL DIRECTOR <u>Spencer T. Elbeck</u>		ADDRESS <u>1129 N. Chestnut</u>					

Lisandro



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6082		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 884	
M.E. CASE NO.		CERTIFICATE OF DEATH		67 6082	
1. NAME OF DECEASED (Type or Print) <b>Rupp, Charlotte V.</b>		2. DATE AND HOUR OF DEATH <b>June 22, 1967 11:40 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bolton Hill Nursing &amp; Convalescent Ctr.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>20-07</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>502 Mt. Holly Street</b>			
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>1/3/06</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marker Gutman Dept. Store</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frederick Rupp</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Drenner</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212 09 3369</b>		17. INFORMANT ADDRESS <b>Mrs Anna G. Lyon 2701 Tivoly Avenue</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>CA of lung with metastases</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>port p exam of CA post</b> <b>heart (infarcted recently)</b> <b>arteriosclerosis generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>years</b> <b>year</b>	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/15</b> 19 <b>67</b> to <b>6/22</b> 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>6/22</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>ALLAN H. MAEHT</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6/23/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALLAN H. MAEHT</b>		23D. ADDRESS <b>2 E. READ ST 2122</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/26/67</b>	24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 23 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HENRY SANDER &amp; SONS INC. BALTIMORE MARYLAND 21213</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6083		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6083	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Virginia R. Bugg</i>		
2. DATE AND HOUR OF DEATH <i>22 June 1967</i>			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
Wesley Home - 2211 W. Rogers Ave.			A. STATE Maryland		
			B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			D. STREET ADDRESS (If rural, give location)		
			2211 W. Rogers Ave.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>29 Sept 1883</i>	9. AGE (In years lost birthday) <i>83</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				North Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John B. Reel		Unknown		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Mr. Sterling T. Bugg - 3009 Rosalie Ave.	
18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			(A) DUE TO <i>Arteriosclerotic cardiovascular disease</i>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO <i>disease</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>13 February</i> 19 <i>67</i> to <i>22 June</i> 19 <i>67</i> , that (I) <i>last</i> saw the deceased alive on <i>20 June</i> 19 <i>67</i> and that in (my) <i>last</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> <i>(did)</i> view the body after death.					
23A. SIGNATURE <i>John W. Barnaby</i>				23B. DATE SIGNED <i>22 June 67</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOHN W. BARNABY</i>				23D. ADDRESS <i>1531 E North Ave</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial				Moreland Memorial Park Cem. Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 23 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fadden</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc. 5305 Harford Rd. #14</i>	

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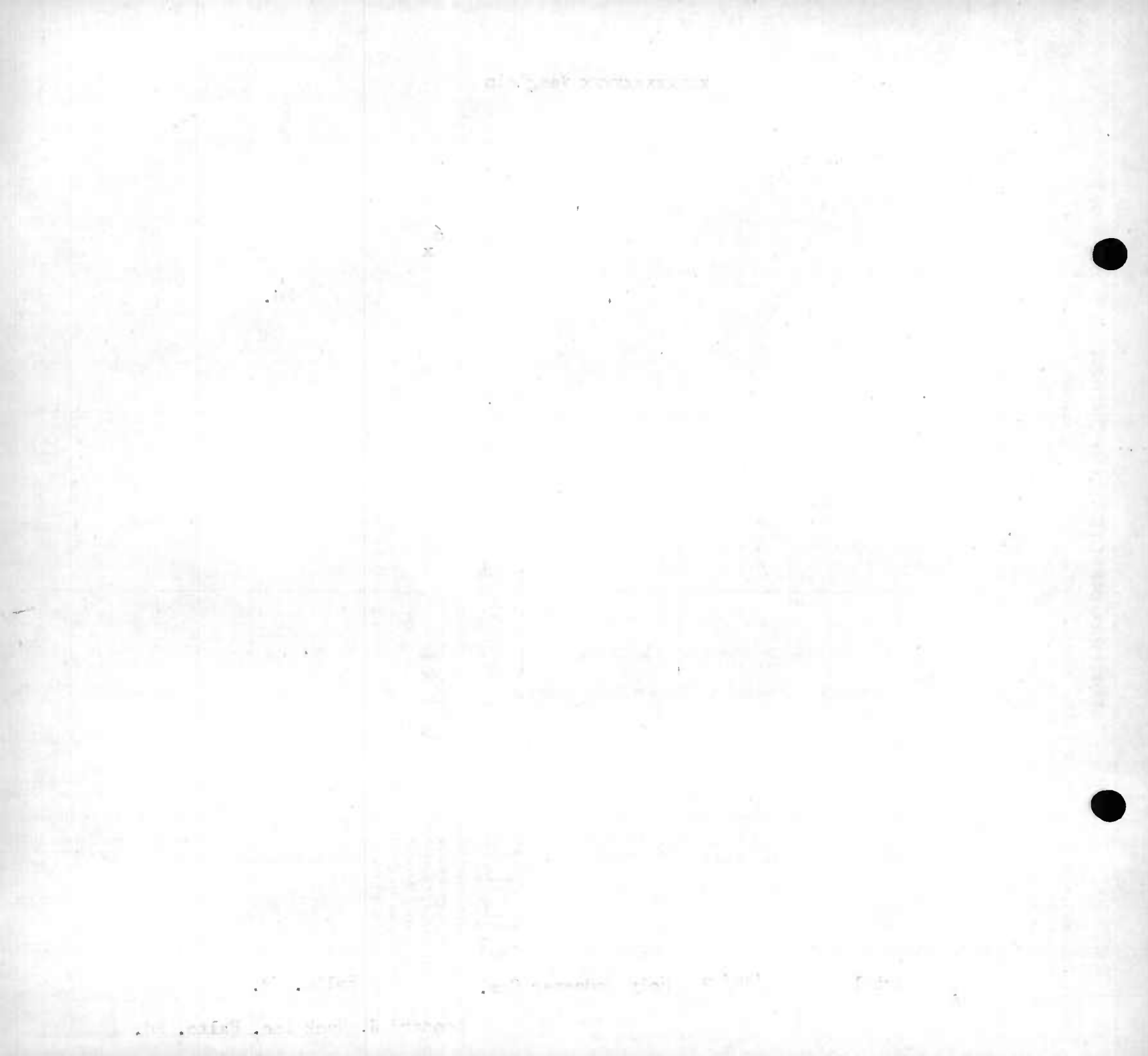
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

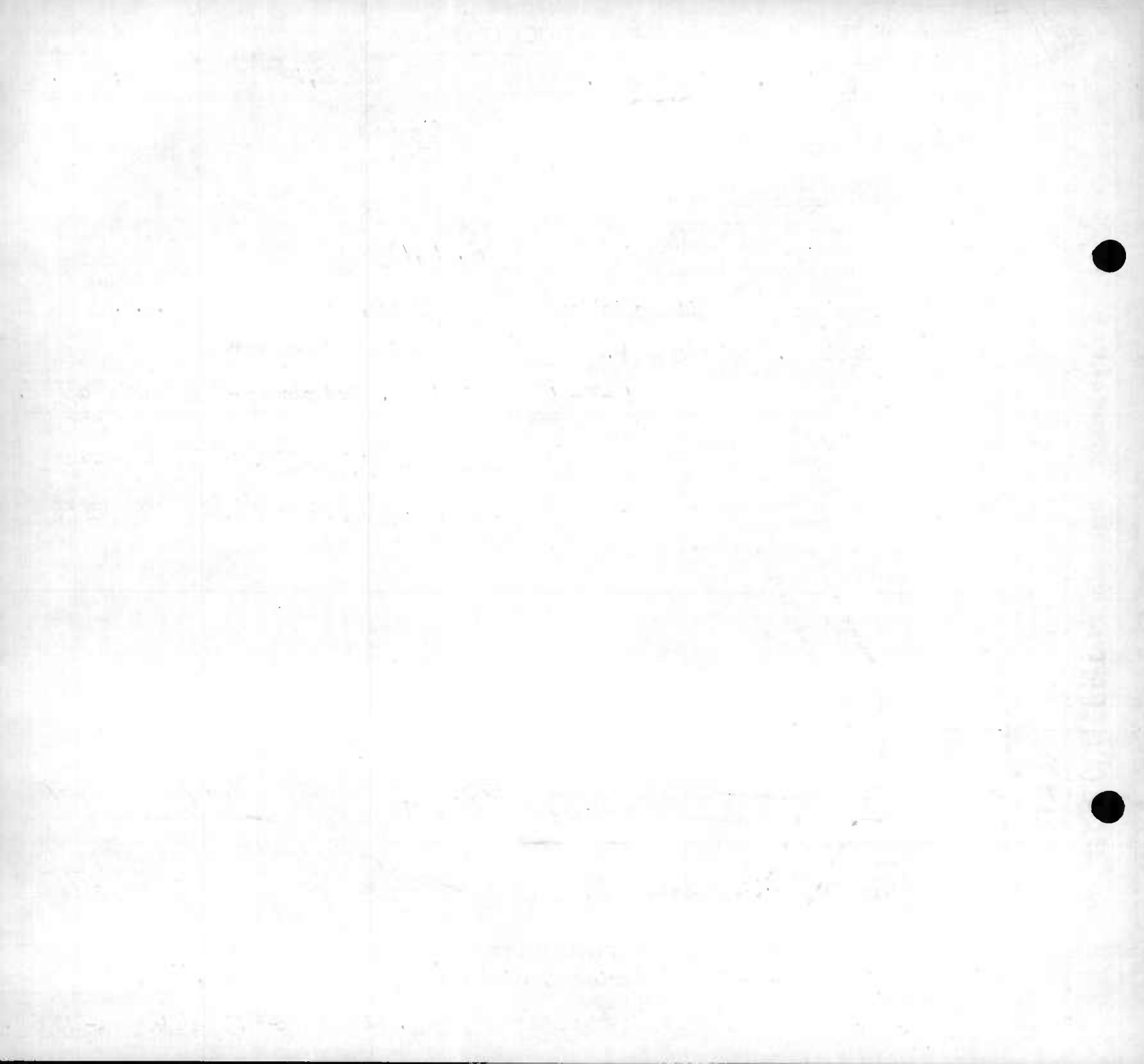
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 6084</b>	
BIRTH NO. <b>67 6084</b>		<b>CERTIFICATE OF DEATH</b>	
M.F. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Joseph F. Voeglein</b>	
2. DATE AND HOUR OF DEATH <b>6-21-67 8:45 P.M.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Little Sisters of The Poor 1200 Valley St., Baltimore, Md. 21202</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>10-01</b>	
5. SEX <b>M</b>		6. RACE <b>W</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>Sept. 5, 1887</b>	
9. AGE (In years last birthday) <b>79</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Voeglein</b>		14. MOTHER'S MAIDEN NAME <b>MARY Fassell</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-22-0932A</b>	
17. INFORMANT <b>Little Srs. of the Poor</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ca of the larynx</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 21</b> to <b>June 21</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>June 21</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Stanley Ankudas</b>		23B. DATE SIGNED <b>6-28-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>STANLEY ANKUDAS</b>		23D. ADDRESS <b>1101 MAIDEN CHOICE LANE BALTO. MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/24/67</b>	
24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 23 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>Balto. Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

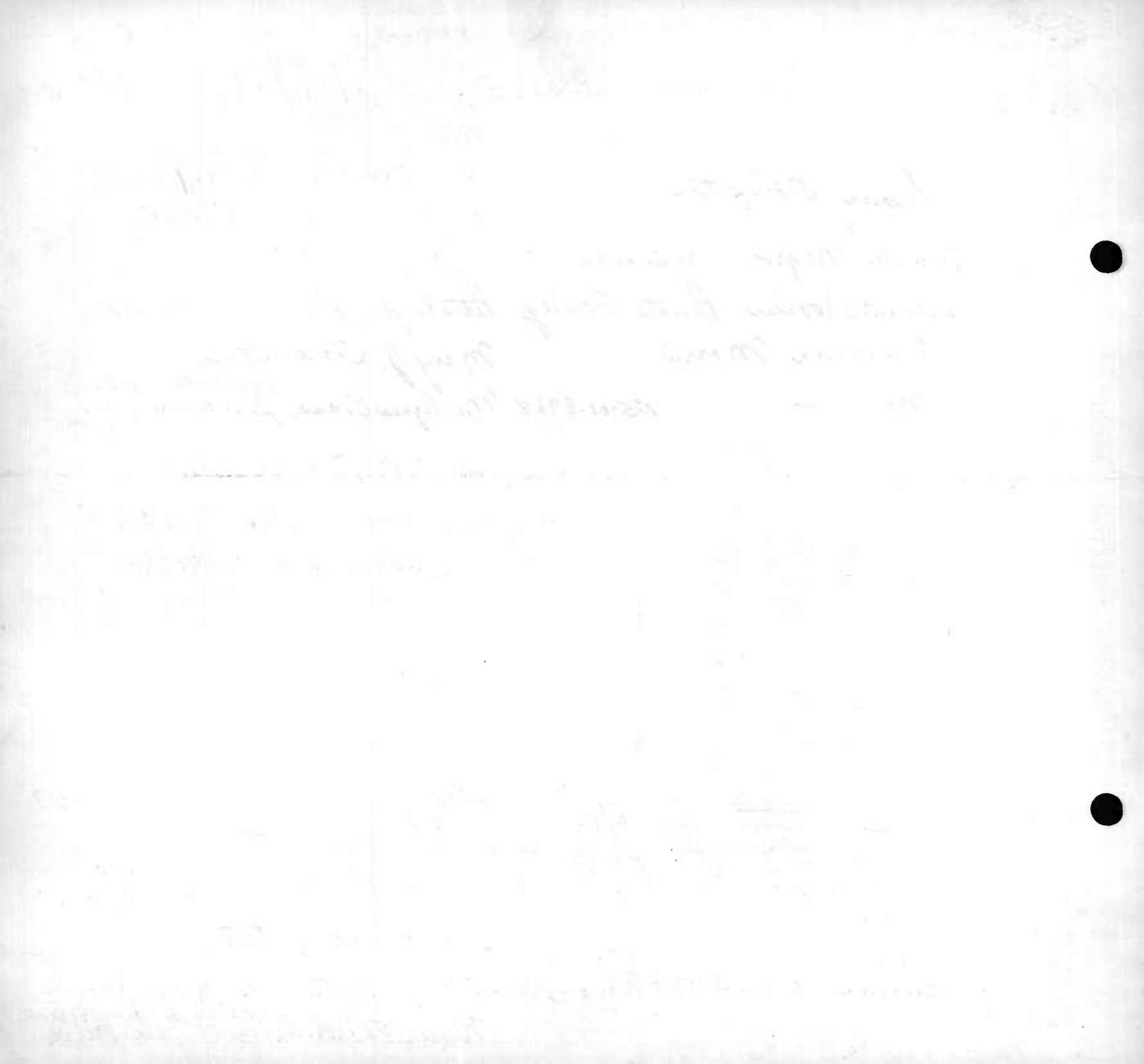
BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 67 6085					CERTIFICATE OF DEATH					Registered No. 67 6085						
1. NAME OF DECEASED (Type or Print) <i>William P. Bartholomay Jr.</i>					2. DATE AND HOUR OF DEATH <i>June 22, 1967</i> <i>8:45 A.</i> M.											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>4403 Marble Hall Road</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>4403 Marble Hall Road</i>											
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>Feb. 18, 1902</i>		9. AGE (In years last birthday) <i>65</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Title Examiner</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>City Solicitor</i>					11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William P. Bartholomay Sr.</i>					14. MOTHER'S MAIDEN NAME <i>Henrietta Scheurmann</i>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>218-22-4150</i>					17. INFORMANT <i>Lillian S. Bartholomay</i>					ADDRESS <i>4403 Marble Hall Rd.</i>	
18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH <i>Arteriosclerotic Cardiovascular Disease</i> (A) DUE TO  <i>Hypertension, Essential</i> (B) DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH <i>29 years</i> <i>10 years</i>						
II																
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>No</i>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?								
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Feb.</i> 19 <i>67</i> to <i>May</i> 19 <i>67</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>3 May</i> 19 <i>67</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>view</del> ) view the body after death.																
23A. SIGNATURE <i>Com. H. Kammer Jr.</i>										M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/23/67</i>				
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS M.D.						
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>6-24-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Lakeview Memorial Park</i>				24D. LOCATION (City, town, or county) (State) <i>Carroll County, Maryland</i>						
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 26 1967</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>				25C. FUNERAL DIRECTOR <i>John C. Miller Inc.</i>				ADDRESS <i>6415 Belair Road-21206</i>				





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6086</b>	
BIRTH NO. <b>67 6086</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>GOODMAN, LOUISE</b>		2. DATE AND HOUR OF DEATH <b>6/19/67 3:05 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinai Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE City 14-03</b> D. STREET ADDRESS (If rural, give location) <b>1810 EUTAW PLACE</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>11/24/05</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>		11. BIRTHPLACE (State or foreign county) <b>Pittsburgh, Pa.</b>	
13. FATHER'S NAME <b>Edward Morris</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Hariston</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>125-01-8968</b>		17. INFORMANT <b>Mrs. Agnes Evans, Baltimore, Md.</b>	
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <b>CAROTID OCCLUSION</b> (B) DUE TO <b>HYPERTENSIVE ARTERIOSCLEROTIC</b> (C) <b>CARDIO VASC. DISEASE.</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/12 1967</b> to <b>6/19 1967</b> , that (I) (we) last saw the deceased alive on <b>6/19 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James Settel</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>6/19/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Sinai Hospital</b>		23D. ADDRESS <b>712-14 E. North Ave. Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-24-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Elmer E. Bedlock</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>67 6087</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b>		Registered No. <b>67 6087</b>	
M.E. CASE NO.		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>Elmer Pettit (ELMER PETTIT)</b>		2. DATE AND HOUR OF DEATH <b>6-21-67 5:00 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>806 W. Pratt St. #21201</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7-20-03</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Elmer Pettit</b>			14. MOTHER'S MAIDEN NAME <b>Jessie Fulton</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-12-1252</b>	17. INFORMANT ADDRESS <b>BCH 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of floor of mouth ~ 1 yr</b>		19. CAUSE OF DEATH <b>215-05-1262</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>9-7</b> 19 <b>67</b> to <b>6-21</b> 19 <b>67</b> , that <del>the</del> (we) last saw the deceased alive on <b>6-21</b> 19 <b>67</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <b>James Corkins</b>				23B. DATE SIGNED <b>6-21-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>James Corkins</b>		23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Md. #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>	24B. DATE <b>6-23-67</b>	24C. NAME of CEMETERY or CREMATORY <b>London Park Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <b>R. E. S. Talley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Connolly Funeral Home - 300 Mace</b>	

2-21-07

Commissioner of Fish and Game

James Perkins

FUNERAL DIRECTOR: IMPORTANT

ate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is an accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6088		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6088	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>RESCHKE, - ADOLPH</b>		2. DATE AND HOUR OF DEATH <b>6-21-67 5:45 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SOUTH GENERAL BALTIMORE HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2904 Michigan Ave</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>3-31-02</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bethlehem Steel Shipyard Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Reschke</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Gatzke</b>		17. INFORMANT ADDRESS <b>Mrs Ella Reschke 2904 Michigan Ave</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>21503-0637</b>			
18. <b>163 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Carcinoma of the Lung</b> DUE TO (B) DUE TO (C) <b>Metastatic Car. of the Brain</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-22-1967</b> to <b>6-21-1967</b> , that (I) (we) last saw the deceased alive on <b>6-21-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jose V. Iglesias</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Jose V. Iglesias</b>		23D. ADDRESS <b>South Baltimore Gen Hosp. 1203 Light St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <b>Meadow Ridge Men.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>		25C. FUNERAL DIRECTOR ADDRESS <b>McCully Funeral Home 237 Baltimore St.</b>	

11A

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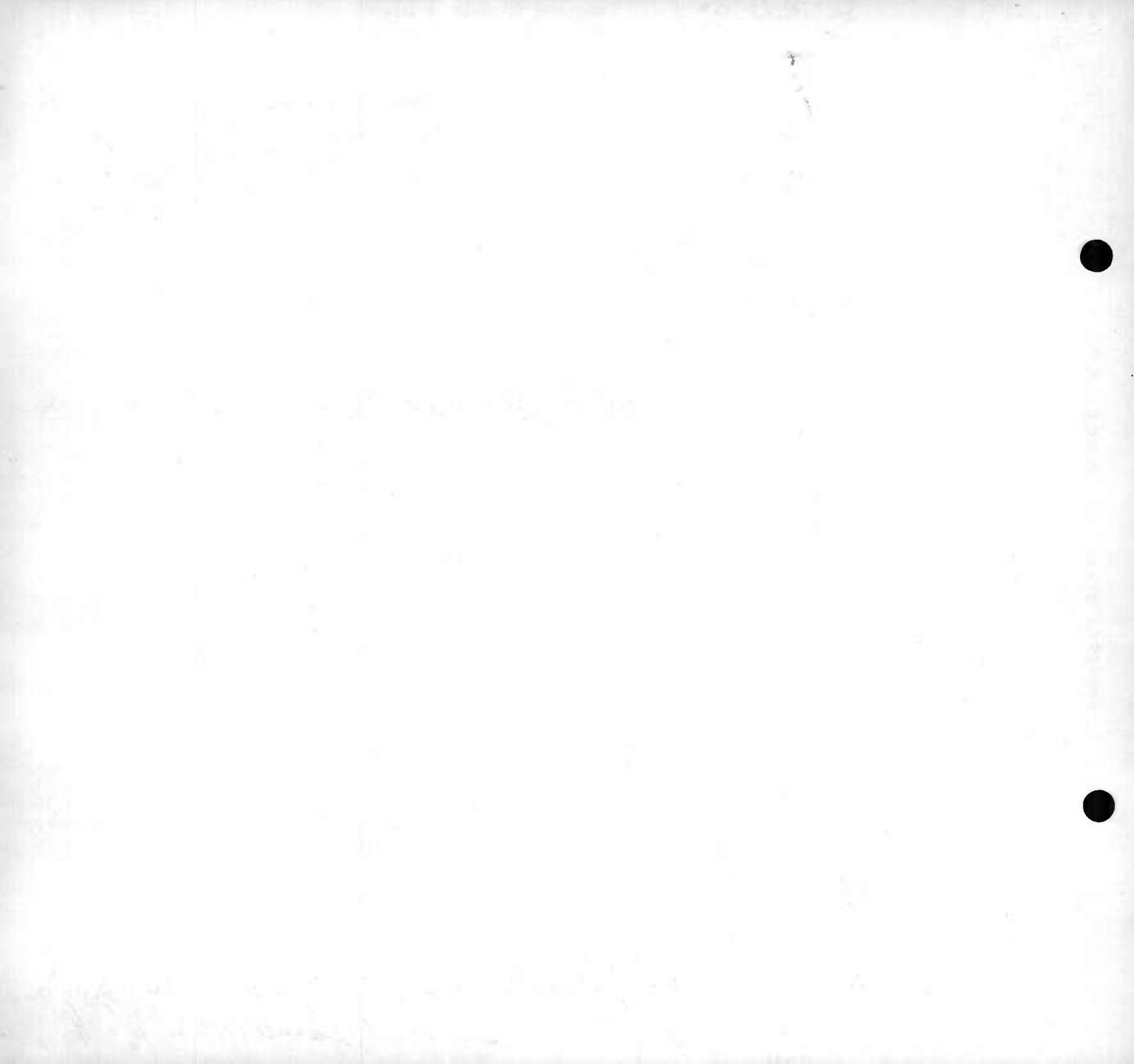
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6088				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6088	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Edward Brown</b>		2. DATE AND HOUR OF DEATH <b>24 JUNE 1967 5:05 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>X</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 18-01</b> D. STREET ADDRESS (If rural, give location) <b>821 W. Santa Rosa St.</b>			
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3/15/93</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-07-5334</b>		17. INFORMANT <b>Victoria Brown-821 W. Santa Rosa St.</b>		ADDRESS	
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <b>Arteriosclerosis AND HYPERTENSIVE</b> (B) <b>CONGENITAL HEART FAILURE</b> (C) <b>ASPIRATION PNEUMONIA</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>R. P. WENZEL</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>24 June '67</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. P. WENZEL</b>				23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>John P. Carroll</b>		ADDRESS <b>1712 W. North</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

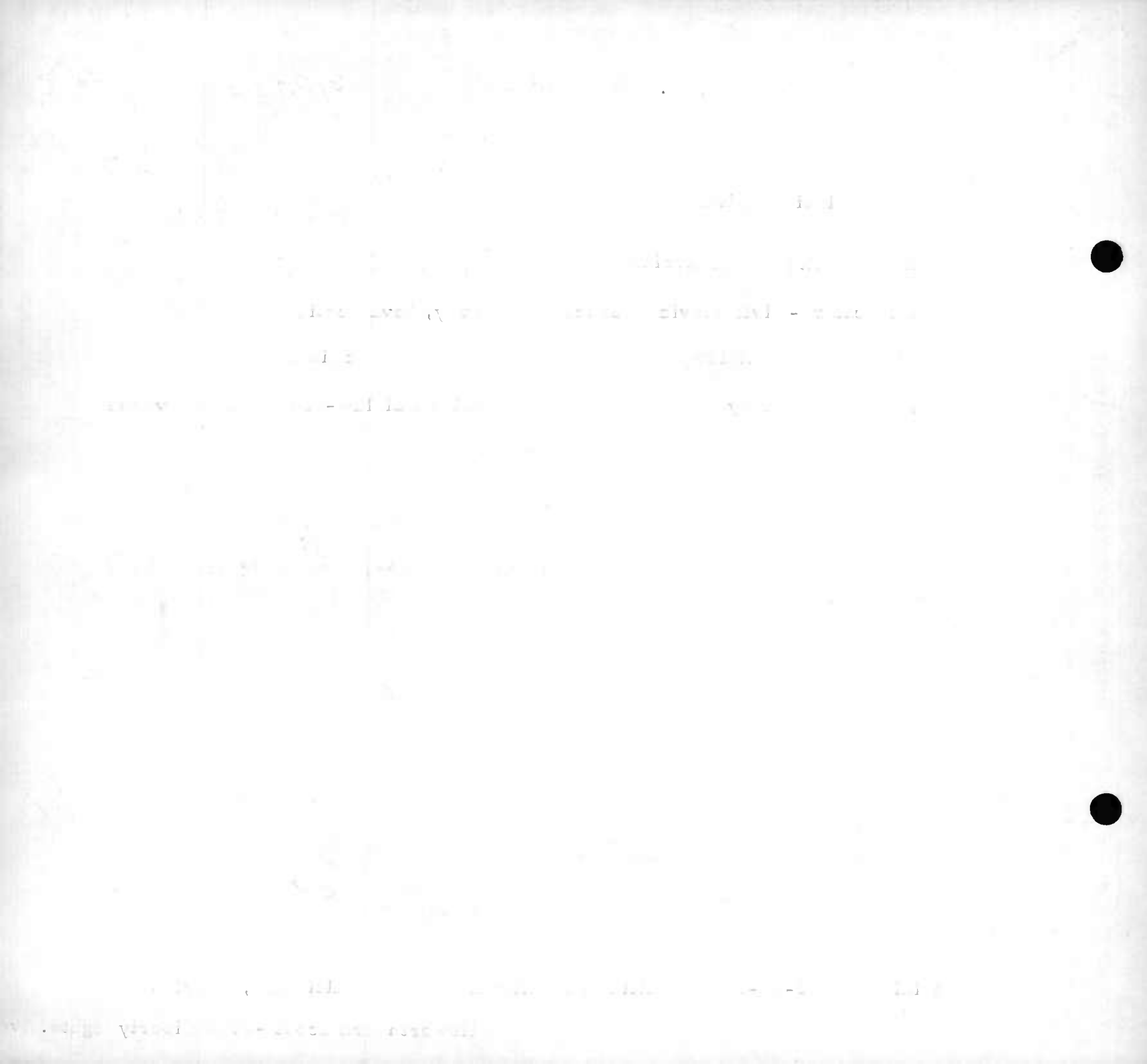
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 6090</b>	
BIRTH NO. <b>67 6090</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WARNER SARA W.</b>	
2. DATE AND HOUR OF DEATH <b>JUNE 25 1967 3:45 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>FRANKLIN SQ. HOSPITAL</b>		A. STATE <b>MD.</b> B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 28-02</b>	
		D. STREET ADDRESS (If rural, give location) <b>3017 OAKHILL AVE</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>11/2/85</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE Nurse</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, months, days) <b>81</b>
11. BIRTHPLACE (State of foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DR. F. S. WARNER</b>		14. MOTHER'S MAIDEN NAME <b>SARA OSENBARGER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216 24 6205</b>	
		17. MARGARET MOONEY - 111 N. CHARLES ST. <b>Hosp. Chart 5+</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) <b>Malignancy, gastric?</b> DUE TO	
		(B) <b>Uremia</b> DUE TO	
		(C) <b>Arteriosclerotic Heart Disease</b> DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH <b>± 3 months</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 23 1967</b> to <b>June 25 1967</b> , that (I) (we) lost saw the deceased alive on <b>June 25 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Robert M. Warner</b> M.D.		23B. DATE SIGNED <b>6/25/67</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-27-67</b>	
24C. NAME OF CEMETERY or CREMATORY <b>LODGE PARK Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <b>R. E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Ellsworth ARMAIST</b>		ADDRESS <b>4601 Liberty Hts</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

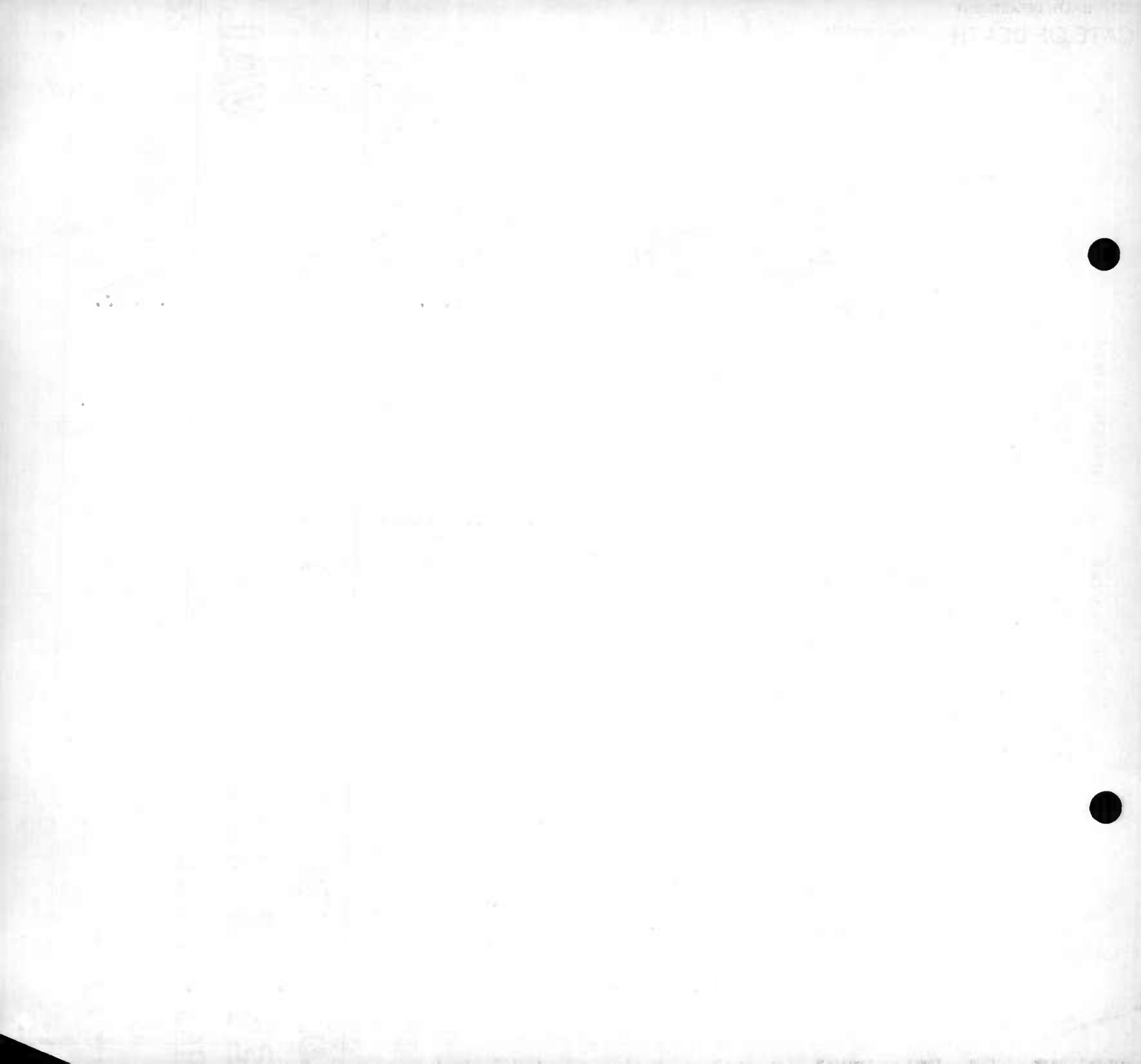
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6091</u>	
BIRTH NO. <u>67 6091</u>		67 6091 <b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>DONALD H. LAIDLAW</u>		2. DATE AND HOUR OF DEATH <u>6/24/67</u> <u>7 55 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>28-41</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE CITY #7</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u>		D. STREET ADDRESS (If rural, give location) <u>5510 HADDON AVE</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>3/3/88</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Cutter - Civil service worker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Troy, Nova Scotia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Laidlaw</u>		14. MOTHER'S MAIDEN NAME <u>McKinnon</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW1 Army</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Louise Laidlaw-5510 Haddon Avenue</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HEART BLOCK</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>MYOCARDIAL INFARCTION</u> <u>ARTERIOSCLEROTIC CARDIOVASC. DISEASE</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/7</u> <u>1967</u> to <u>6/24</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>6/24</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James Soler</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/24/67</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-28-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 26 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Ellsworth Armacost -4600 Liberty Hgts. Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 6092	
CERTIFICATE OF DEATH				Registered No. 67 6092	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>HOLMAN, PEARLINE</b>	
2. DATE AND HOUR OF DEATH <b>6-24-67 14-15 A.M.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Lutheran Hospital of Maryland</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-06</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>1705 Rosedale St.</b>					
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>		8. DATE OF BIRTH <b>2-17-1910</b>	9. AGE (In years last birthday) <b>57 yrs</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jeff Adams</b>			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>James Holman</b>		ADDRESS <b>1705 Rosedale St.</b>			
18. <b>422.1 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arterio Sclerotic Cardio Vascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Brain Syndrome</b> <b>Pneumonia, Euraemia</b>		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-26-1967</b> to <b>6-24-1967</b> , that (I) (we) last saw the deceased alive on <b>6-24-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anjoshi</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-24-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ANIL M. JOSHI</b>		23D. ADDRESS <b>Lutheran Hospital of Maryland, 730 Ashburton St., Baltimore, 21216</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-28-67</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Kelson Funeral Home</b>	
ADDRESS <b>1348 Calhoun St.</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6093</b>	
BIRTH NO. <b>67 6093</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type name) <b>Marie Lizzie Carey</b>		2. DATE AND HOUR OF DEATH <b>6-23-67 11 P.M. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bolton Hill Nursing Home</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Virginia</b> B. COUNTY <b>Hague</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Rt. 1 Box 14</b> D. STREET ADDRESS (If rural, give location)			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-27-90</b>	9. AGE (In years lost birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
13. FATHER'S NAME <b>Thompson Reed</b>		14. MOTHER'S MAIDEN NAME <b>Ann Kelly</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Records, Bolton Hill Nursing Home</b>	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>A25.C.V.D.</b> DUE TO (B) <b>Left hemiplegia &amp; dysphagia.</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Ellsworth Cook</b> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/28/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Zion Church Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Oldham, Va.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>F. H. 1328 Calhoun</b>	

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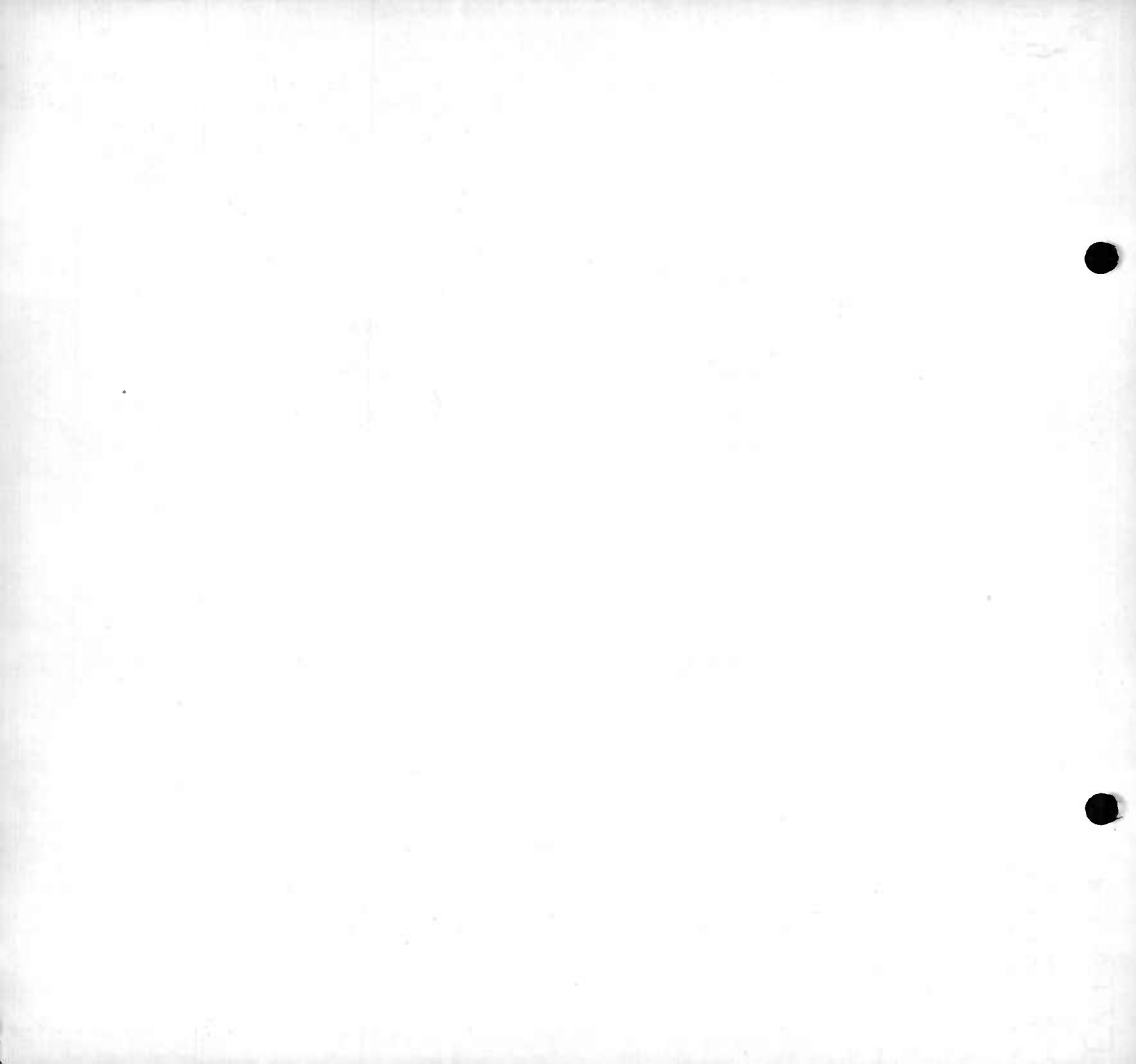
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6094		67 6094		67 6094	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		Vernon Robinson		6/22/67 4:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
University Hospital		Md Balto		Balto	
D. STREET ADDRESS (If rural, give location)		1805 Penn Ave		14-03	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	Negro	Separated	5-12-04	63	Old Jobs
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Md		USA		Isaac Robinson	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Maggie Ballot		No		17. INFORMANT ADDRESS	
MARGARET ROBINSON		1025 Carey St.		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH		19. MEDICAL CERTIFICATION	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Hemorrhage	
ANTECEDENT CAUSES		(B) DUE TO		Lung Abscess erosion	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		Probable Ca	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
II		No		No	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
0		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from 6/18 1967 to 6/22 1967, that (I) (we) last saw the deceased alive on 6/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
James Arnold		6/22/67		James E. Arnold M.D.	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Univ. Hosp		Burial		6-26-67	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.	
Mt. Auburn Cem.		Balto. Md		JUN 26 1967	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
R. E. E. Fisher M.D.		Kelson Funeral Home		1348 Calhoun St.	



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67 6095

BALTIMORE CITY HEALTH DEPARTMENT

67 6095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FLORENCE LANDON

2. DATE AND HOUR PRONOUNCED DEAD

June 22, 1967 4:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

708 Newington Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12-24-14

9. AGE (In years last birthday)

52

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

George Landon 708 Newington Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Reservoir St. 142' west of Callow Ave.

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) (Minute)  
6-22-67 3:25 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by truck

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 23, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

6-27-67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county) (State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 26 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Kelson Funeral Home 1348 Calhoun St.

ADDRESS

N 869 2 7000 6105

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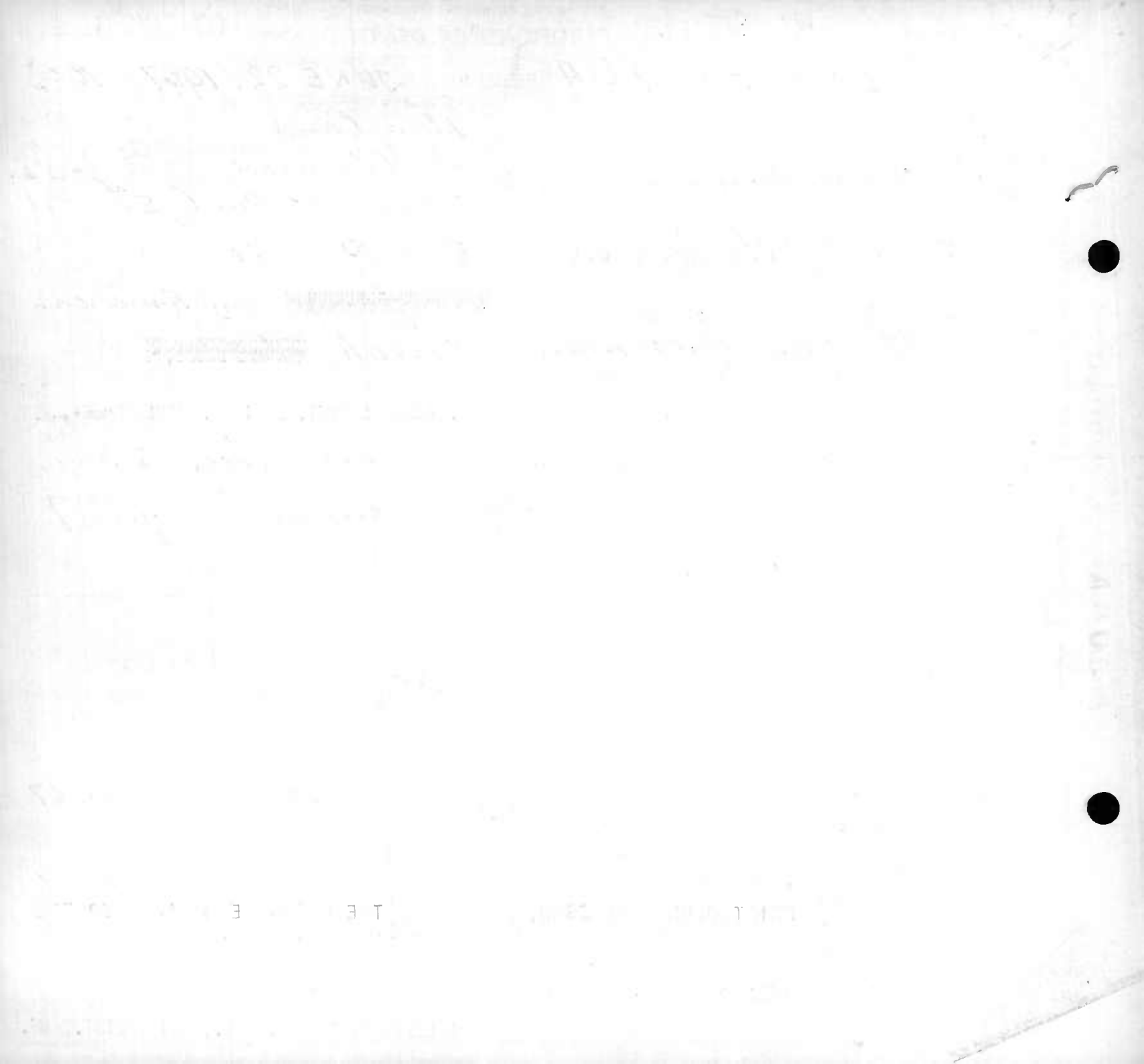
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6096					Registered No. 67 6096				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>LERNER, IDA PRESSMAN</b>					2. DATE AND HOUR OF DEATH <b>JUNE 22, 1967 1030 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>					A. STATE <b>Maryland</b>				
(If not in hospital or institution, give street address or location)					B. COUNTY				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)				
<b>Baltimore</b>					<b>3501 St Paul St #1</b>				
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>Married</b>	8. DATE OF BIRTH <b>05-20-90</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>			11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>Abraham Pressman</b>					14. MOTHER'S MAIDEN NAME <b>Sarah</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>MR. LOUIS LERNER, 3501 ST. PAUL STREET, APT 241</b>			ADDRESS	
18. <b>331X I</b>					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					<b>Cerebral hemorrhage</b>				
ANTECEDENT CAUSES					<b>Hyper tension</b>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>many years</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>6-22 6 PM 1967</b> to <b>6-22 1030 PM 1967</b> , that (I) (we) last saw the deceased alive on <b>6-22 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Fred Jofar Bjornsson</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>6-22-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRIDTJOFAR BJORNSSON</b>					23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL Union Memorial Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>6/23/67</b>		24C. NAME of CEMETERY or CREMATORY <b>SHOMREI HADATH</b>			24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 23 1967</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6097</b>	
BIRTH NO. <b>67 6097</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ISADORE KARLIN</b>		2. DATE AND HOUR OF DEATH <b>JUNE 22, 1967 9:25 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE</b>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 15-13</b>	
		D. STREET ADDRESS (If rural, give location) <b>4203 PARK HEIGHTS AVE</b>			
5. SEX <b>M.</b>	6. RACE <b>CAUC.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JAN. 7, 1885</b>	9. AGE (In years lost birthday) <b>82</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED-TAILOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>FACTORY</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>SAMUEL JOSEPH KARLIN</b>		14. MOTHER'S MAIDEN NAME <b>SARAH ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>MR. JOSEPH KARLIN, 6227 PINLICO ROAD, Apt B</b>	
18. <b>4203 I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>PROBABLE MYOCARDIAL INFARCTION</b>		(A) DUE TO		<b>24 HRS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>6/21</u> 19 <u>67</u> to <u>6/22</u> 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>6/22</u> 19 <u>67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <b>Melvyn B. Lewis</b>				23B. DATE SIGNED <b>6/22/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>MELVYN B. LEWIS</b>				23D. ADDRESS <b>SINAI HOSPITAL OF BALTO.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/23/67</b>		24C. NAME of CEMETERY or CREMATORY <b>SHAAREI ZION</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>			
25B. NAME OF REGISTRAR <b>John E. Ford</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>			

C

Mr

ME



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.5em;">67 6098</span>	
BIRTH NO. <span style="font-size: 1.5em;">67 6098</span>		<b>CERTIFICATE OF DEATH</b>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">6-22-67</span> <span style="font-size: 1.5em;">2:30 P.M.</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">MOLLIE WOLFE</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.5em;">Md</span> B. COUNTY <span style="font-size: 1.5em;">Baltimore</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.5em;">LEVINDALE AGED HOME</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.5em;">Baltimore</span>		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.5em;">Levindale Hebrew Home &amp; Infirmary, Md, 21215</span>	
5. SEX <span style="font-size: 1.5em;">W F</span>	6. RACE <span style="font-size: 1.5em;">W</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.5em;">NEVER MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.5em;">4-2-1896</span>	9. AGE (In years last birthday) <span style="font-size: 1.5em;">71</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">House work</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.5em;">Domestic</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Baltimore, Md.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.5em;">David Wolfe</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Bessie ?</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">219-38-7919</span>		17. INFORMANT <span style="font-size: 1.5em;">Mrs. Hannah Schnitzer, 2715 B Hanson Avenue</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.5em;">Malignant Lymphoma (Hodgkin sarcoma type)</span>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">2 yrs.</span>	
<p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION <span style="font-size: 1.5em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">No</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">11-29-1966</span> to <span style="font-size: 1.5em;">6-22-1967</span> , that (1) (we) last saw the deceased alive on <span style="font-size: 1.5em;">6-22-1967</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">J. Ardaiz</span>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.5em;">6-22-67</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">Jose ARDAIZ</span>		23D. ADDRESS M.D. <span style="font-size: 1.5em;">5912 Cross Country Blvd. Baltimore, Md 21215</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>		24B. DATE <span style="font-size: 1.5em;">6/23/67</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.5em;">Oheh Vahov</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Baltimore, Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">JUN 26 1967</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Fisher</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.5em;">Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6099		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6099	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>MADELINE MOLDEN</b>			2. DATE AND HOUR OF DEATH <b>June 20, 1967</b> <b>6 P.</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2309 Roslyn Ave</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>16-02</b> D. STREET ADDRESS (If rural, give location) <b>1316 W. Lafayette Ave</b>		
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b> DIVORCED (specify)	8. DATE OF BIRTH <b>July 1884</b>	9. AGE (In years lost birthday) <b>83</b> <b>2</b>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James Parr</b>			14. MOTHER'S MAIDEN NAME <b>Ataway Branson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-32-8036</b>	17. INFORMANT <b>2422 ADDRESS W Mr Hammond J. Briscoe Invalet St</b>		
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerosis Cardio-vascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 19</b> 19 <b>67</b> to <b>June 20</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>June 19</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Louis T. Lavy</b>			23B. DATE SIGNED <b>Aug 23 1967</b>		
23C. PHYSICIAN'S NAME (Type) <b>DR. LOUIS T. LAVY</b>			23D. ADDRESS <b>3502 W. Popes Ave Baltimore 15710</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6-24-67</b>	24C. NAME of CEMETERY or CREMATORY <b>Cathedral Cem</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>Mrs. Frances A. Housley</b> ADDRESS <b>1578 W. Blk</b>			

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Subject

Reference

See also 10-10-61

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10-10-61

67 6100

BALTIMORE CITY HEALTH DEPARTMENT

67 6100

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DAVID

P.

MC CARTIN

2. DATE AND HOUR PRONOUNCED DEAD

June 23, 1967

6:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6014 Alta Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

Nov 21 1954

9. AGE (In years  
last birthday)

12

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles L. McCartin Sr

14. MOTHER'S MAIDEN NAME

Alma M. MARKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

Charles L McCartin Sr 6014 Alta Ave 21206

ADDRESS

18. E 935.4

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Struck by Lightning  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Ball Field

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Moyer and Rosalie Sts. 27-05

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
June 23, '67 5:55  
p. m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

struck by lightning at Little League game

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/24/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6-26-67

23C. NAME of CEMETERY or CREMATORY

Parkwood Cem.

23D. LOCATION

(City, town, or county)

(State)

3310 Taylor Ave Balto 21234

24A. DATE REC'D BY HEALTH DEPT.

JUN 26 1967

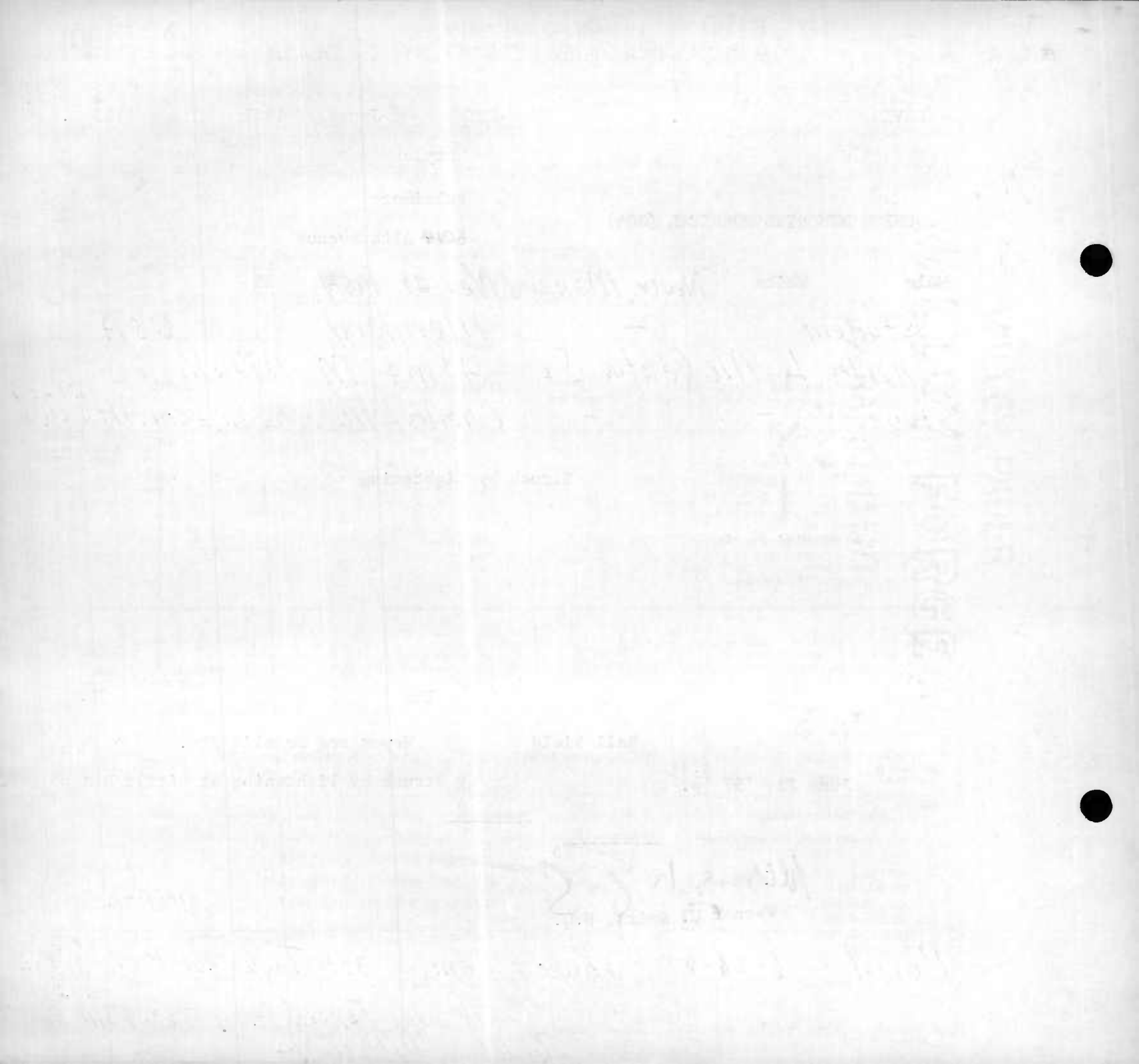
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Burgee Funeral Home 3631 Falls Rd 21211

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6101	
BIRTH NO. 67 6101		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MILLARD F. JOSEPHANS		2. DATE AND HOUR OF DEATH JUNE 22 1967 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived) (If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTO. CITY HOSP		A. STATE MD. B. COUNTY BALTO			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ESSEX 53-00			
		D. STREET ADDRESS (If rural, give location) 1513 OLD EASTERN AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH FEB 20 1910	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF-EMPLOYED -		10B. KIND OF BUSINESS OR INDUSTRY L	11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FREDERICH W. JOSEPHANS			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 217-03-1784		17. INFORMANT ADDRESS DOROTHY JOSEPHANS ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Myocardial infarction DUE TO (B) Arteriosclerotic coronary DUE TO (C) heart disease with coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH June 22, 1967 Dec 1966	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 7 1955 to June 19 67, that (I) (we) last saw the deceased alive on June 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles M. Kerr M.D.				23B. DATE SIGNED June 23, 67	
23C. PHYSICIAN'S NAME (Type) Charles M. Kerr, M.D.				23D. ADDRESS 6801 Belair Road 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/26/67		24C. NAME OF CEMETERY or CREMATORY MORELANDS	
24D. LOCATION BALTO. MD.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1967		25B. NAME OF REGISTRAR R. E. E. Taylor		25C. FUNERAL DIRECTOR J. D. GONNELLE SONS	
				ADDRESS 300 MACE	

My dear Mr. [unclear]  
I have just received your letter  
of the 10th inst. and am  
glad to hear that you are  
well.

Yours very truly  
[unclear]  
June 10, 1880



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6102		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6102	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LOUIS L. YOST SR.</u>		2. DATE AND HOUR OF DEATH <u>JUNE 21, 1967</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		26-07	
D. STREET ADDRESS (If rural, give location)		615 S. OLDHAM ST			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 13, 1910</u>	9. AGE (In years last birthday) <u>57</u>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FLORIST</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN YOST SR.</u>		14. MOTHER'S MAIDEN NAME <u>MARIE JAEGER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>GRACE YOST ABOVE</u>	
18. <u>153.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <u>Carcinoma of ascending colon</u> DUE TO (B) <u>Anemia, marked</u> DUE TO (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> <u>2 mo.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>24 Apr 67</u> 19 to <u>21 Jun 67</u> 19 that (I) (we) last saw the deceased alive on <u>6 Jun 67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. B. Bronushas</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>23 Jun 67</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. B. BRONUSHAS, M.D.</u>		23D. ADDRESS <u>3057 O' DONNELL ST. BALTO. MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>6/26/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>LOUEN PARK</u>	
24D. LOCATION (City, town, or county) <u>BALTO. MD</u>		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 26 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>J.G. CONNELLY 300 MALE</u>	

Received of Mr. J. B. Brown  
the sum of \$100.00  
for the purchase of land

27th Nov. 1872

J. B. Brown

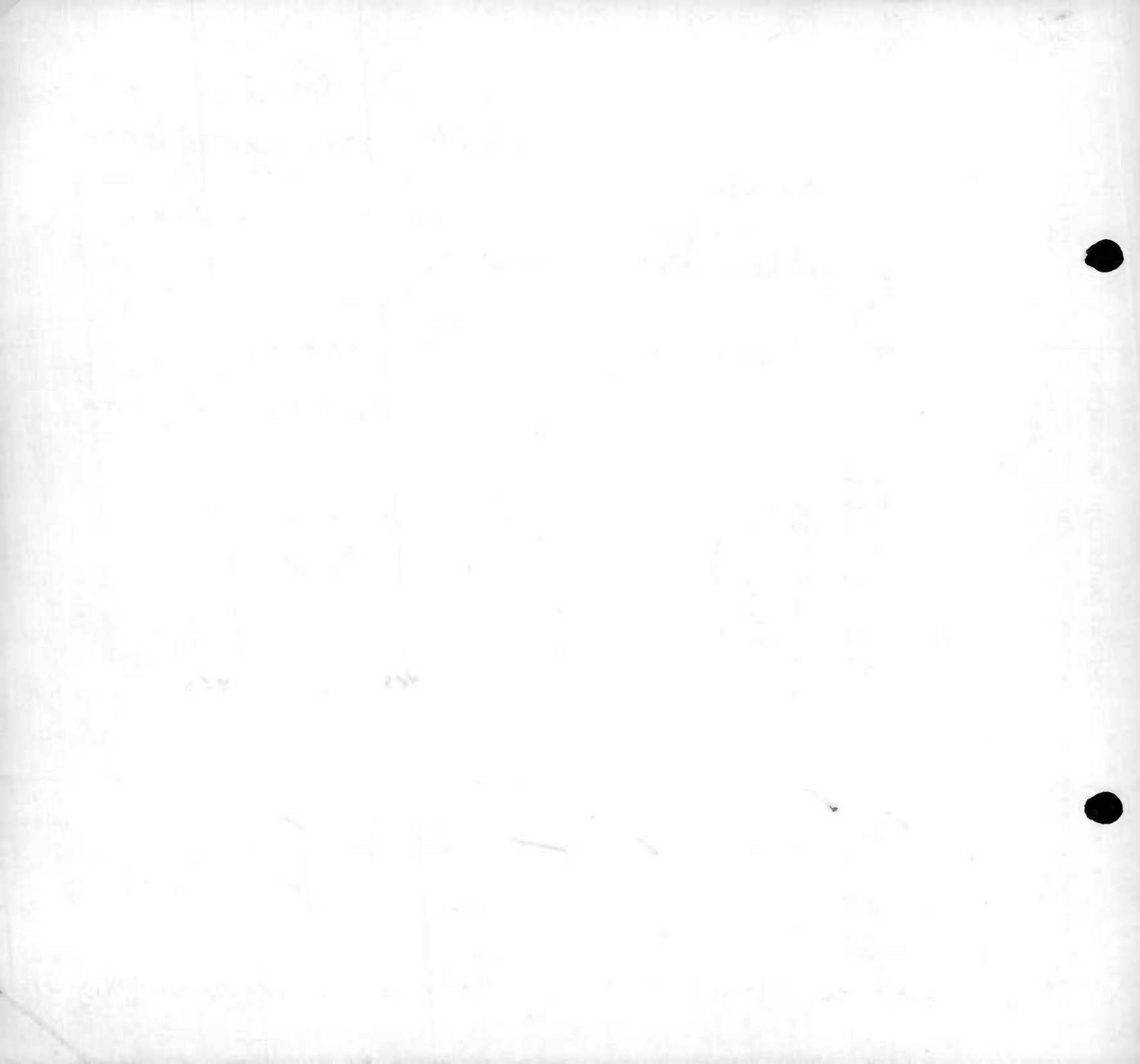
100 B. Brown

27th Nov. 1872

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67-1214367</b> <b>6103</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 6103</b>	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		<b>BABY BOY BADOLATO</b>		<b>6-20-67 4:00 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		<b>MARYLAND BALTIMORE</b>	
<b>BON SECOURS</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<b>DUNDALK 6370</b>	
D. STREET ADDRESS (If rural, give location)		<b>72 ADMIRAL BLVD.</b>		E. ZIP CODE	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
<b>MALE</b>		<b>WHITE</b>		<b>NEVER MARRIED</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
				<b>6/20/67</b>	
9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>1hr.</b>		<b>BALTIMORE, MD.</b>		<b>USA.</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)	
<b>BARTHOLOMEW BADOLATO</b>		<b>Shirley MASKOL</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH	
<b>B. BADOLATO</b>		<b>Same #4</b>		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)	
<b>2</b>		<b>762.51</b>		(A) <b>Prematurity</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		(B) <b>Anemia sec. to Hemorrhage</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		(C) <b>Congenital Alelutanis</b>	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (H) (this hospital) attended the deceased from <b>6/20/67</b> to <b>6/20</b> 19 <b>67</b> , that (H) (we) last saw the deceased alive on <b>6/20</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
<b>Grace Ayngar</b>		<b>6-20-67</b>		<b>GRACE AY4YA0</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>BURIAL</b>		<b>6/23/67</b>		<b>BALTIMORE NATIONAL</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>JUN 26 1967</b>		<b>Robert E. Taylor</b>		<b>BALTIMORE, MD. 21222</b>	



RELEASED BY MEDICAL EXAMINER  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

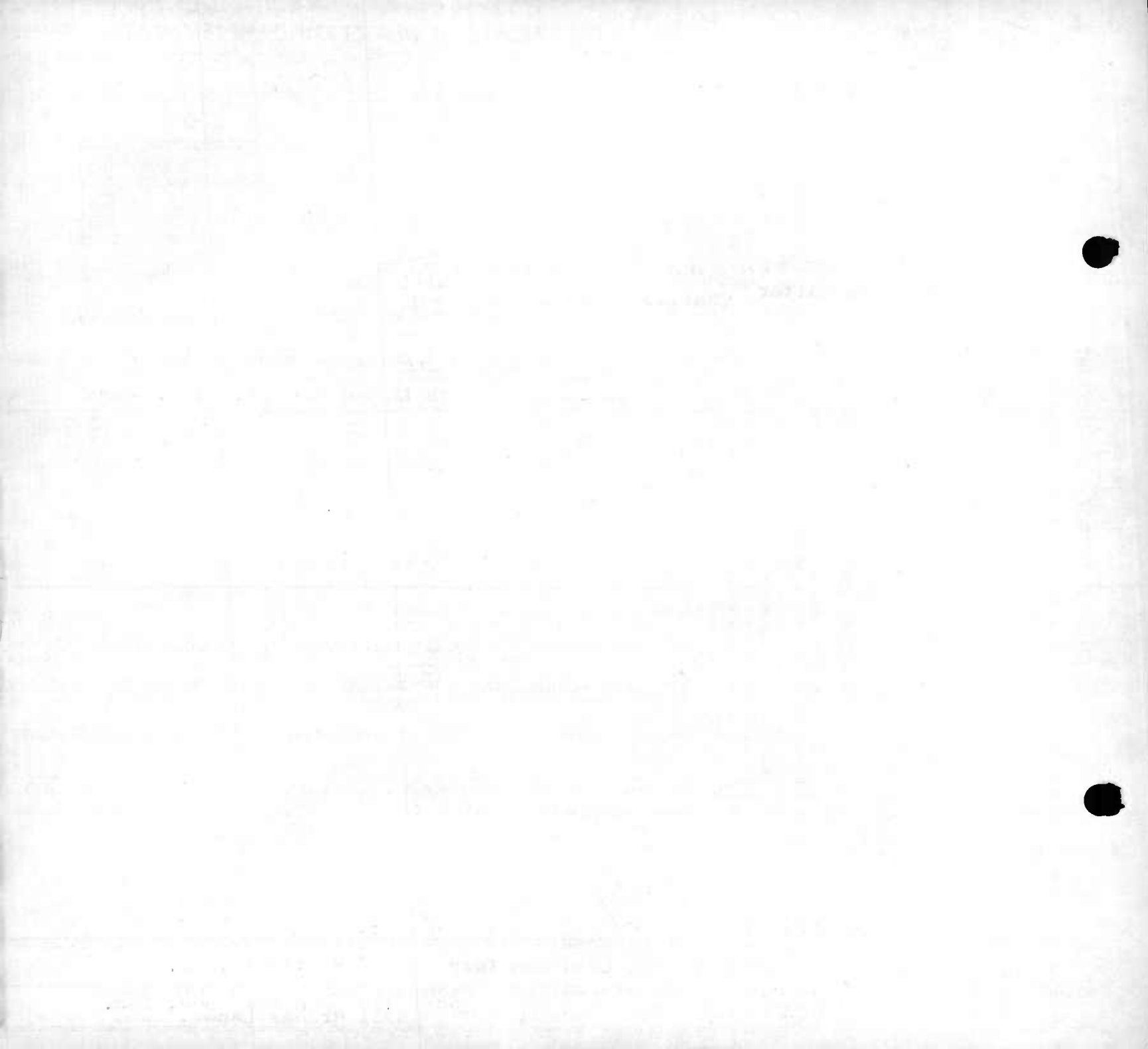
BIRTH NO. 67 6104		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6104	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) TREUTH, CHARLES WILLIAM		2. DATE AND HOUR OF DEATH JUNE 20 1967 12:38 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL		A. STATE MD. B. COUNTY BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21228 Catonsville (rural)			
		D. STREET ADDRESS (If rural, give location) 334 OELLA AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED SINGLE DIVORCED	8. DATE OF BIRTH 11-10-15	9. AGE (In years last birthday) 51	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER RETAIL		10B. KIND OF BUSINESS OR INDUSTRY MEAT BUSINESS		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOHN W. TREUTH			
14. MOTHER'S MAIDEN NAME MINNIE DILL		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 215-03 8798		17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death) ACUTE MYOCARDIAL INFARCT DUE TO CARDIAC ARREST DUE TO A.S.C.V.D.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 230 min	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Emphysema			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 5 1967 to JUNE 20 1967, that (I) (we) last saw the deceased alive on JUNE 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank M. Detorie		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-20-67	
23C. PHYSICIAN'S NAME (Type) FRANK DETORIE		23D. ADDRESS CATON AND WILKENS AVE. BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) ENTOMBMENT		24B. DATE 6/23/1967		24C. NAME of CEMETERY or CREMATORY LORRAINE MAUSOLEUM	
24D. LOCATION WOODLAWN, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 26 1967			
25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR Eastern Funeral Home Catonsville, Md.			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6105	
BIRTH NO. 67 6105		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>FRANK J. CHILDS</b>		2. DATE AND HOUR OF DEATH <b>6/20/67 1230 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION <b>7 MERCY HOSPITAL</b>		(If not in hospital or institution, give street address or location)		<b>Md.</b>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<b>BALTIMORE 9-06</b>	
		D. STREET ADDRESS (If rural, give location)		<b>1714 CHILTON ST.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>9/19/98</b>	9. AGE (In years lost birthday) <b>68</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clothing Cutter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Charles Banks &amp; Sons</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>FRANK CHILDS</b>		14. MOTHER'S MAIDEN NAME <b>CARRIE XXXXXX Lillies</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-01-8656</b>		17. INFORMANT ADDRESS <b>Etta Lanham Childs, wife, above</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>327.2</b>		CAUSE OF DEATH (A) <b>PROBABLE PULMONARY EDEMA DUE TO</b> (B) <b>COR PULMONALE DUE TO</b> (C) <b>CHRONIC OBST. LUNG DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>CHRONIC</b> <b>CHRONIC</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>None</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/9</b> 19 <b>67</b> to <b>6/20</b> 19 <b>67</b> , that (II) (we) last saw the deceased alive on <b>6/20</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Barry Ominsky</b>				23B. DATE SIGNED <b>6/20/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>BARRY OMINSKY</b>		23D. ADDRESS <b>MERCY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/23/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <b>P. E. E. J. J. J.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>	

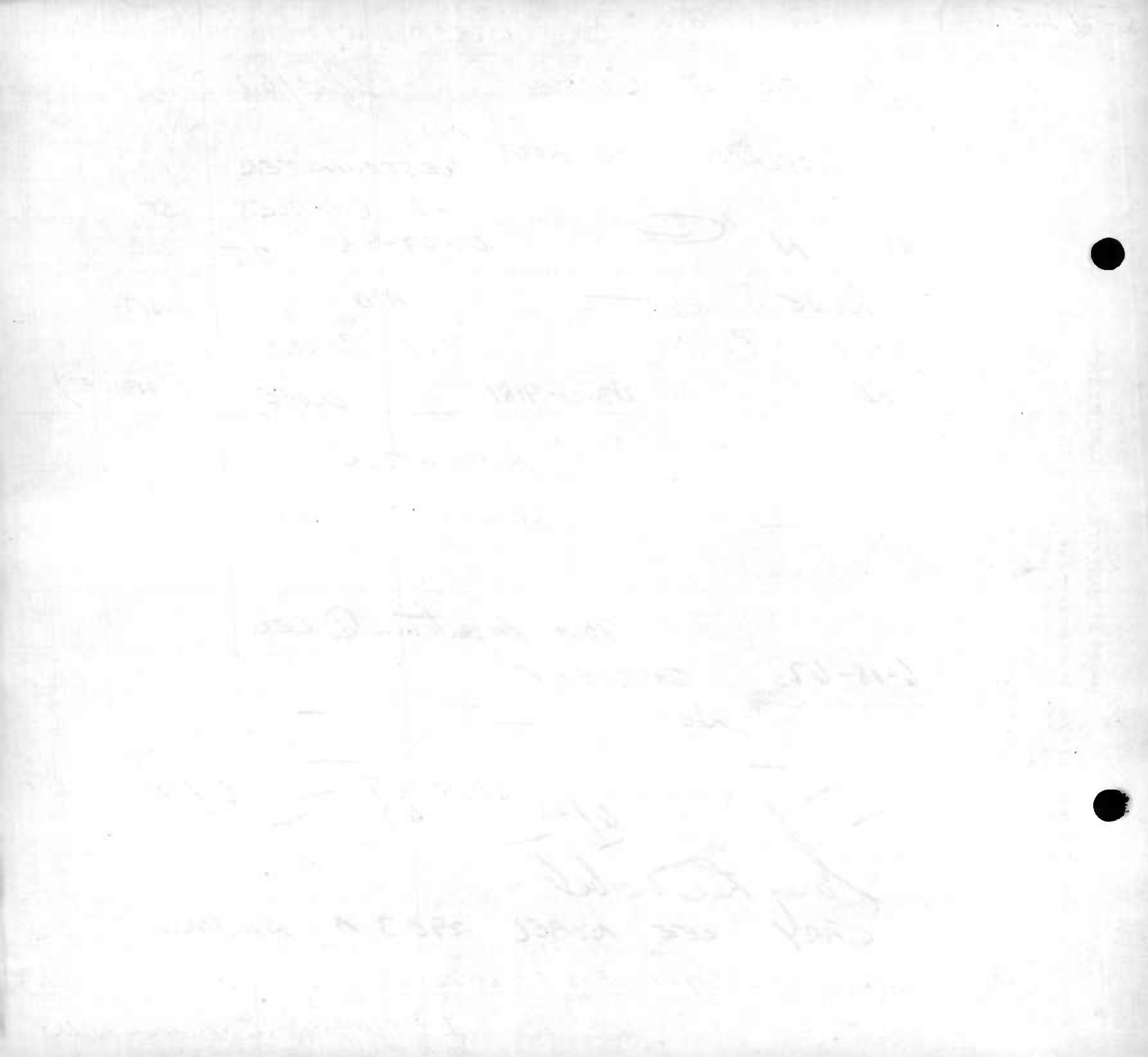




FUNERAL DIRECTOR: IMPORTANT

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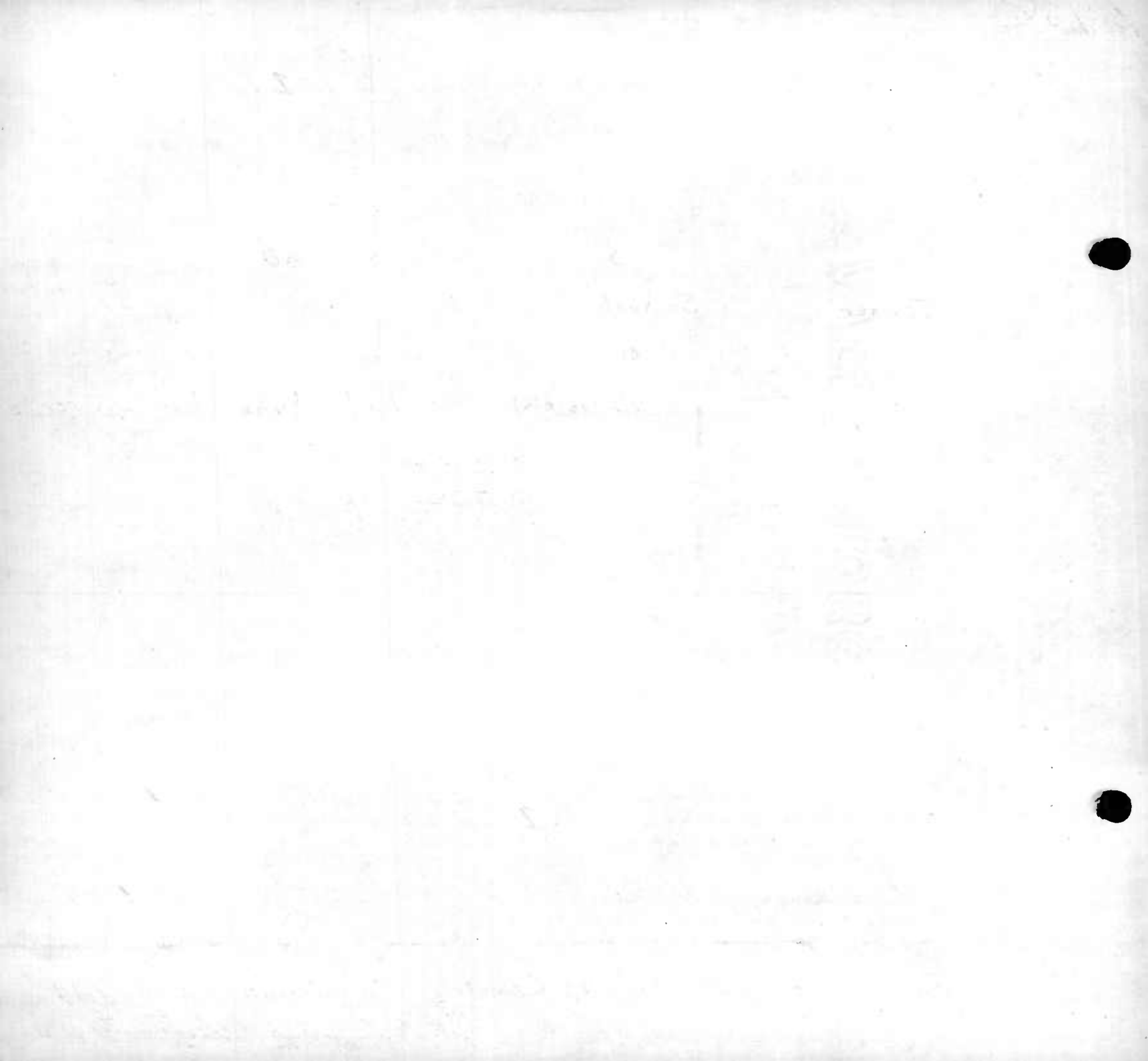
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6106	
CERTIFICATE OF DEATH					
BIRTH NO. 67 6106					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) LUTHER E. GIBSON		2. DATE AND HOUR OF DEATH 6/23/67 3:05 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY Carroll			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GEN. HOSP.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) WESTMINSTER 36-27			
		D. STREET ADDRESS (If rural, give location) 27 CHARLES ST.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 05-07-92	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE RETIRED COOK		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN GIBSON		14. MOTHER'S MAIDEN NAME MARY BARNHART			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-9181		17. INFORMANT WIFE ADDRESS (ABOVE)	
18. 433X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ASPIRATION DUE TO (B) GANGRENE OF LEG DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Post Amputation @ LEG					
19A. DATE OF OPERATION 6-18-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6/15/67 to 6/23/67, that (I) last saw the deceased alive on 6/23/67 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Gary Lee Nobel				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) GARY LEE NOBEL		23D. ADDRESS 2903 A Andover Rd MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/27/67		24C. NAME of CEMETERY or CREMATORY GARDENS OF ETERNAL HOPE	
		24D. LOCATION (City, town, or county) (State) FINKSBURG RD 1 MD.			
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR J. E. Myer, Jr. Westminister, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67		6107		67 6107	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Alice Elizabeth Billmyer</u>			6/22/67 4 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Carroll</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University of Maryland Hospital</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Westminster</u> <u>56-00</u>		
			D. STREET ADDRESS (If rural, give location) <u>RFD #5</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>S</u>	8. DATE OF BIRTH <u>12/3/00</u>	9. AGE (In years lost birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Scott S. Billmyer</u>			14. MOTHER'S MAIDEN NAME <u>Mary Stevenson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-8267</u>		17. INFORMANT ADDRESS <u>Mrs Paul Kuhns Westminster, Md</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastases to liver</u>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>					
19A. DATE OF OPERATION <u>6-23-67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/12/67</u> to <u>6/22/67</u> , that (I) (we) last saw the deceased alive on <u>6/22/67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sandra Z. Sacan</u> M.D.				23B. DATE SIGNED <u>6/22/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Sandra Z. Sacan</u>		23D. ADDRESS <u>Univ. of Maryland Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-23-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Kriders Cemetery</u>	
24D. LOCATION <u>Westminster Carroll Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 26 1967</u>		25B. NAME OF REGISTRAR <u>R. E. B. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John E. Myers Jr. Westminster, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6108	
CERTIFICATE OF DEATH					
BIRTH NO. 67 6108		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) John Leo Neuner			2. DATE AND HOUR OF DEATH 6/23/67 8:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		A. STATE Maryland B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 18 S. Potomac St			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-18-02	9. AGE (In years last birthday) 64	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car inspector		10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John M. Neuner		14. MOTHER'S MAIDEN NAME Mary E. Shaw	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 71769-7119		17. INFORMANT Patient chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 199.21		CAUSE OF DEATH (A) Metastatic Adenocarcinoma		INTERVAL BETWEEN ONSET AND DEATH ?	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 6-6-1967 to 6-23-1967, that (A) (we) last saw the deceased alive on 6/23-1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John R. Vaughn Jr.				23B. DATE SIGNED 6-23-67	
23C. PHYSICIAN'S NAME (Type) JOHN R. VAUGHN JR.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/67		24C. NAME OF CEMETERY or CREMATORY Oakland Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		24E. DATE REC'D BY HEALTH DEPT. JUN 26 1967		24F. NAME OF REGISTRAR Robert E. [unclear]	
24G. FUNERAL DIRECTOR B. Dabrowski		24H. ADDRESS 2818 E. Baltimore St.			

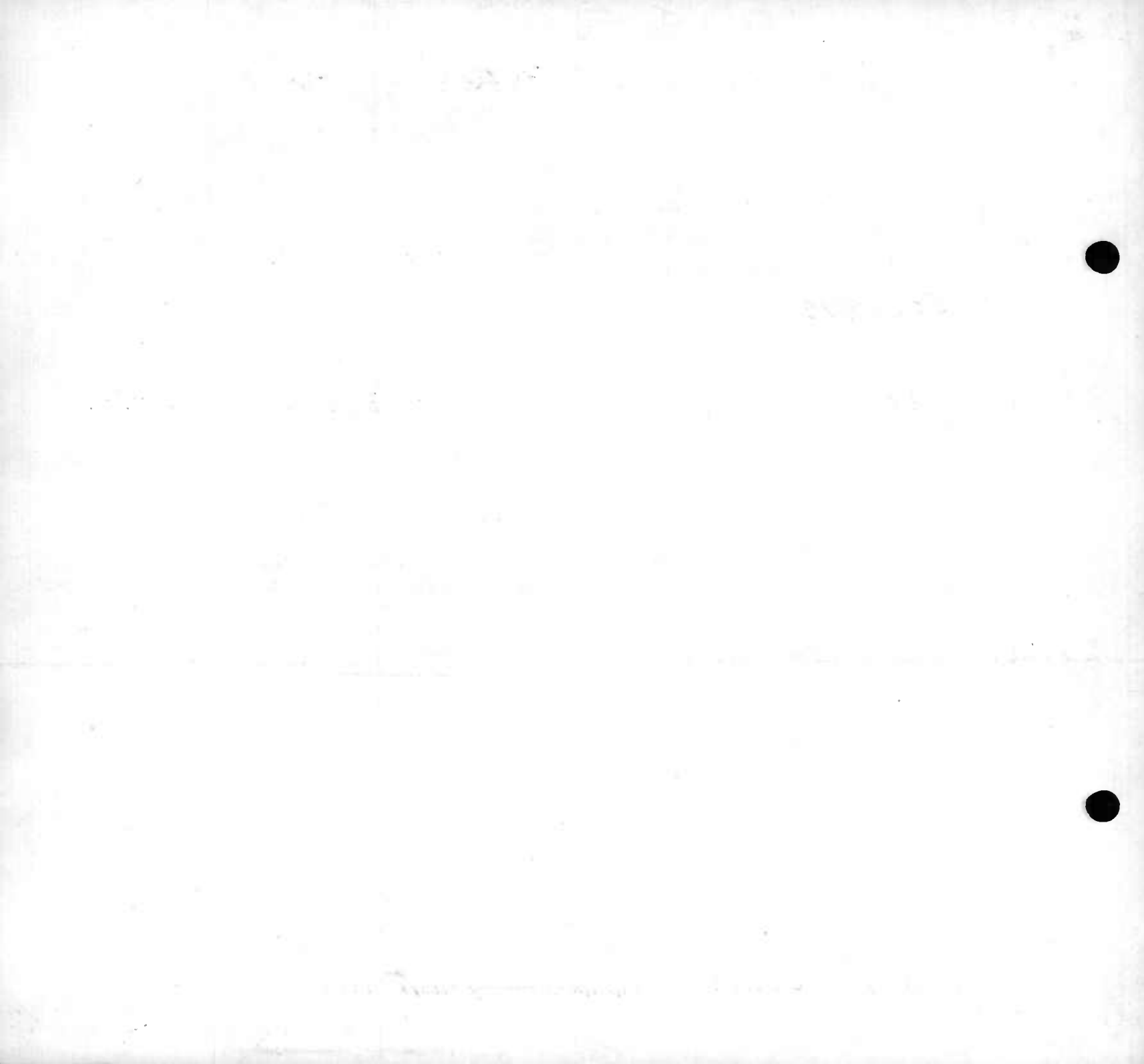
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6109				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 844 67 6109	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Jina Thomas (E. Butler)		6/23/67 12 45	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Bolton Hill Nursing Home				Maryland 16-01			
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Female C Widowed				Baltimore			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				D. STREET ADDRESS (If rural, give location)			
Domestic				1211 W. Lanvale St.			
10B. KIND OF BUSINESS OR INDUSTRY				8. DATE OF BIRTH		9. AGE (In years lost birthday)	
				1/18/95		72	
13. FATHER'S NAME				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
John Thomas				Balto. Md.		U. S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				319-30-605 1A		William Hallway 208 N. Unity St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				Cerebral thrombosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				Arteriosclerotic heart disease			
				Arteriosclerosis generalized			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/20 1967 to 6/23 1967, that (I) (we) last saw the deceased alive on 6/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		23E. FUNERAL DIRECTOR	
ALLAN A. MACHT M.D.				2 East Reed St 21202		Williams Funeral Home Schenck St.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/26/67		Arbutus Memorial Park Arbutus Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 26 1967		J. E. Taylor, M.D.		Williams Funeral Home		319 N. Schenck St.	

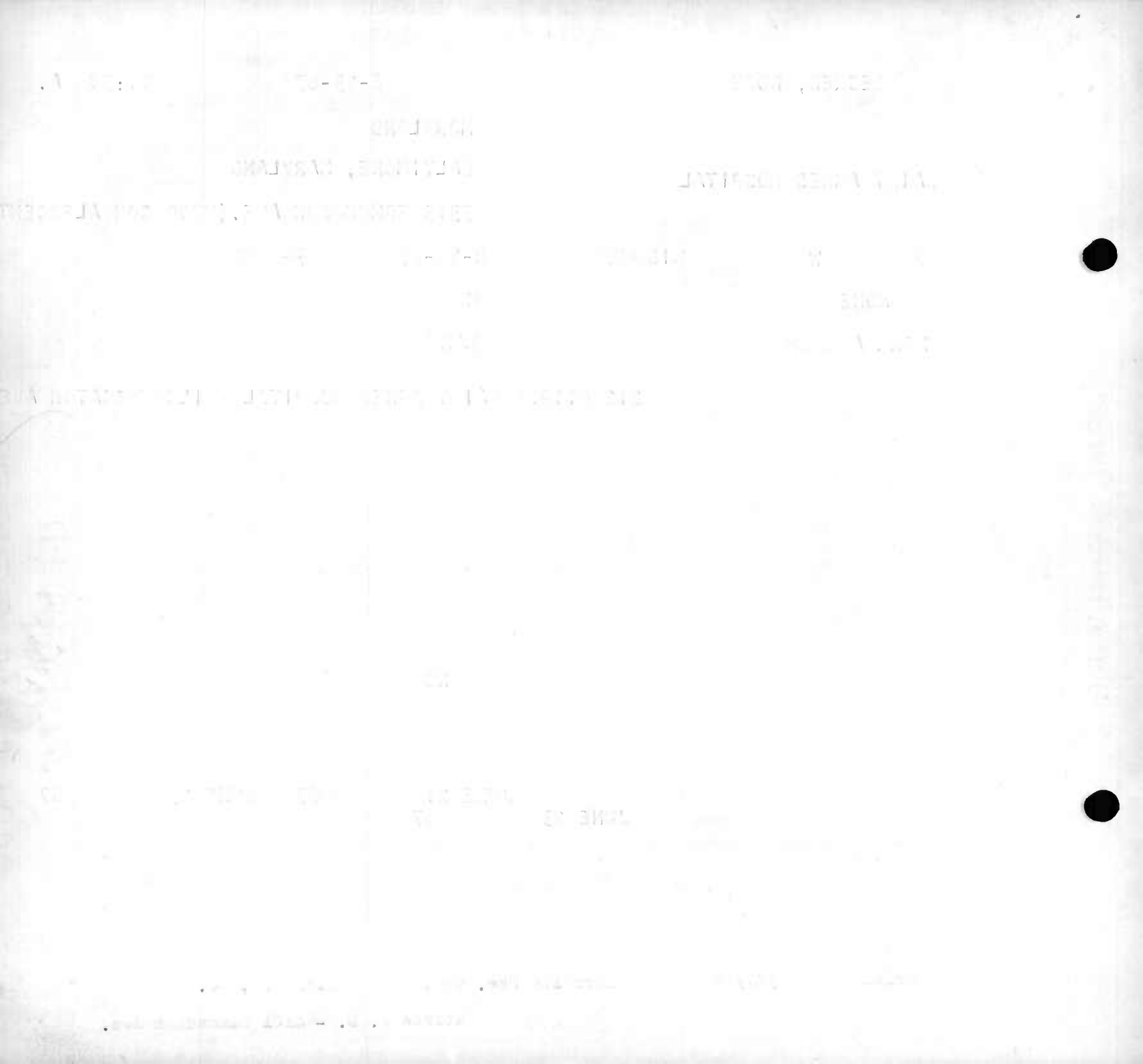




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

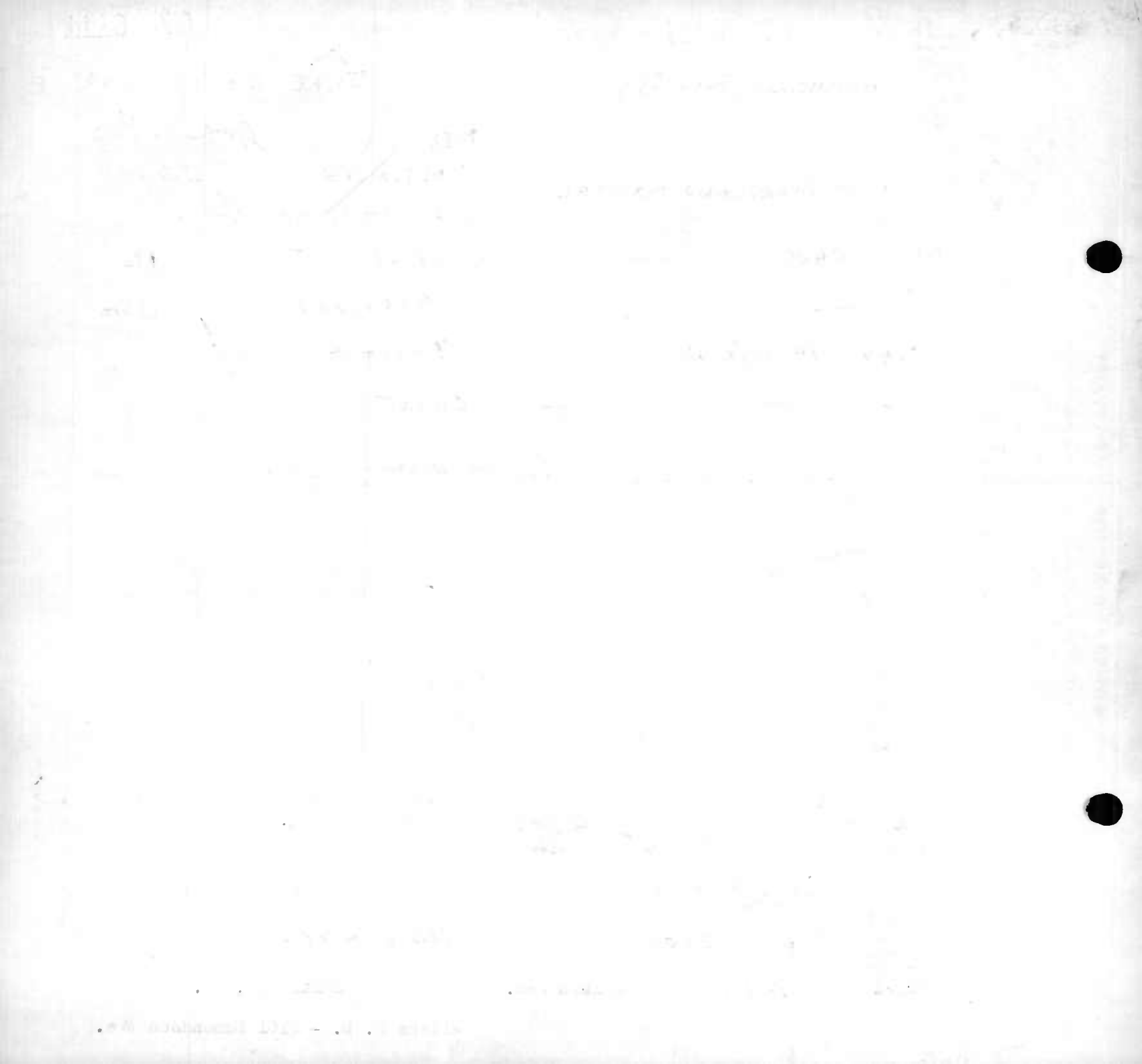
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 6110					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 6110				
1. NAME OF DECEASED (Type or Print) <b>BECKER, ROSE</b>					2. DATE AND HOUR OF DEATH <b>6-23-67 11:50 A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>28-04</b>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SAINT AGNES HOSPITAL</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE, MARYLAND</b>				
					D. STREET ADDRESS (If rural, give location) <b>5313 EDMONDSON AVE. (HOOD CONVALESCENT</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>4-28-87</b>	9. AGE (In years - last birthday) <b>78 80</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>FRANK A BUSH</b>					14. MOTHER'S MAIDEN NAME <b>MARY</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>212 011986</b>		17. INFORMANT ADDRESS <b>SAINT AGNES HOSPITAL WILKENS &amp; CATON AVE</b>				
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <b>Acute coronary Thrombosis 72 hrs.</b> DUE TO (B) <b>A.S.C.V.D. myocardial degeneration</b> DUE TO (C) <b>Diabetes mellitus</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Paralytic ileus</b>					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>JUNE 21 19 67</b> to <b>JUNE 23 19 67</b> , that (I) (we) last saw the deceased alive on <b>JUNE 23 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>M. N. Hattarki</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>06 24 67</b>		
23C. PHYSICIAN'S NAME (Type) <i>M. N. Hattarki</i>		23D. ADDRESS <b>54 Agnes Hospital 1008 S. Calver Ave Baltimore #29</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/27/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Pke. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <i>R. E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Wtitzke F. D. - 4101 Edmondson Ave.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

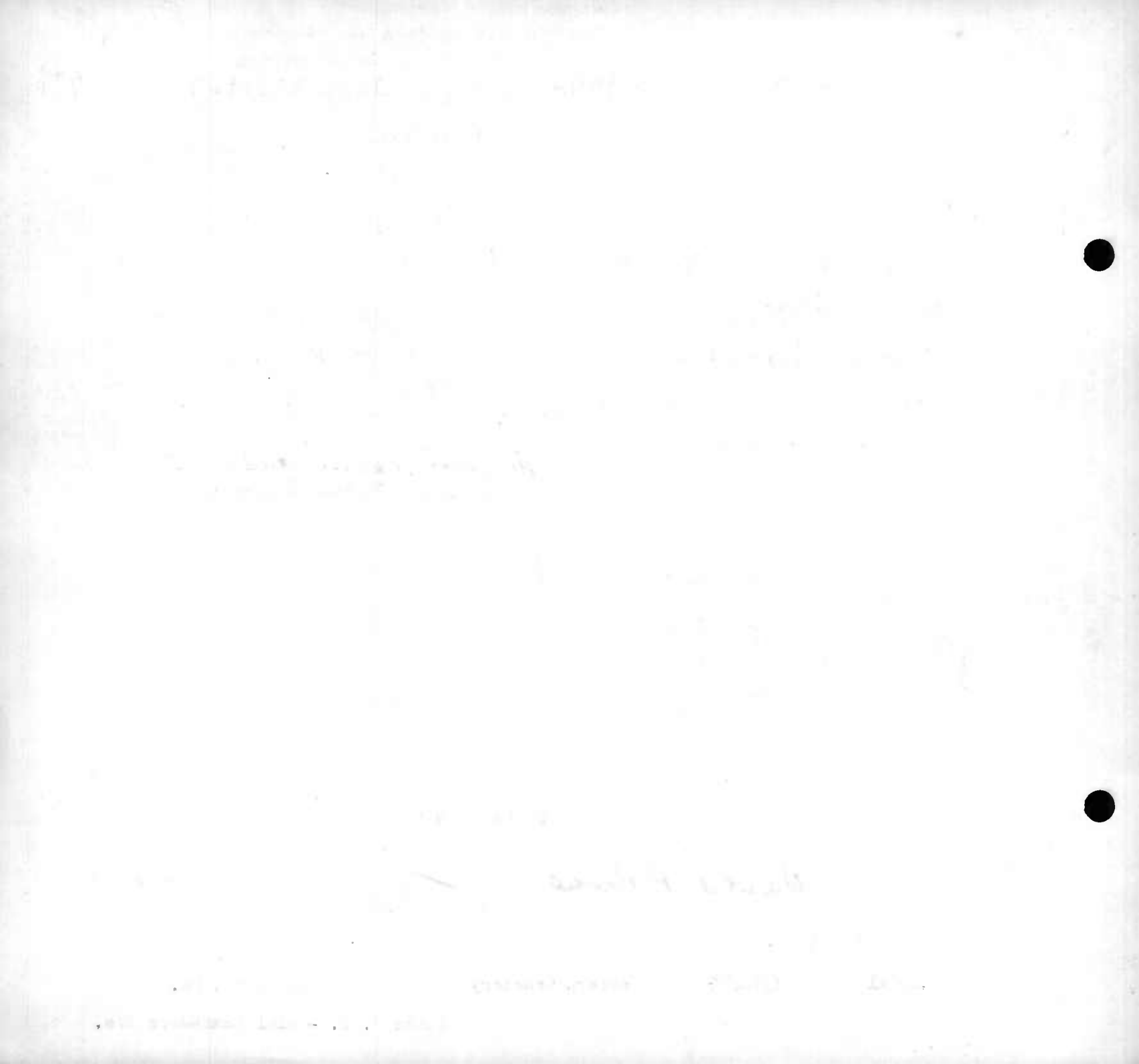
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 6111	
BIRTH NO. 67-13228 67 6111										CERTIFICATE OF DEATH	
M.E. CASE NO.										2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HAMMONDS, BABY BOY</b>										<b>JUNE 23 '67 1035 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived - If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIV. OF MARYLAND HOSPITAL</b>										A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>	
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
										D. STREET ADDRESS (If rural, give location) <b>1925 Hillside Dr.</b>	
5. SEX <b>M</b>		6. RACE <b>CAUC.</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>6-22-67</b>		9. AGE (In years last birthday)		If Under 1 Yr. Months Days <b>1 1/2</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RAY HAMMONDS</b>						14. MOTHER'S MAIDEN NAME <b>BARBARA</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHART</b>				ADDRESS	
18. <b>320X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>tension pneumothorax</b> DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>6-22 1967</b> to <b>6-23 1967</b> , that (we) last saw the deceased alive on <b>6-23 1967</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.											
23A. SIGNATURE <b>M.B. Keeler</b>										23B. DATE SIGNED <b>6-23-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>M.B. KEELER</b>										23D. ADDRESS <b>UNIV. HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>6/26/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cem.</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>				25B. NAME OF REGISTRAR <b>Robert E. Farley</b>				25C. FUNERAL DIRECTOR ADDRESS <b>Witzke F. D. - 4101 Edmondson Ave.</b>			



FUNERAL DIRECTOR: IMPORTANT

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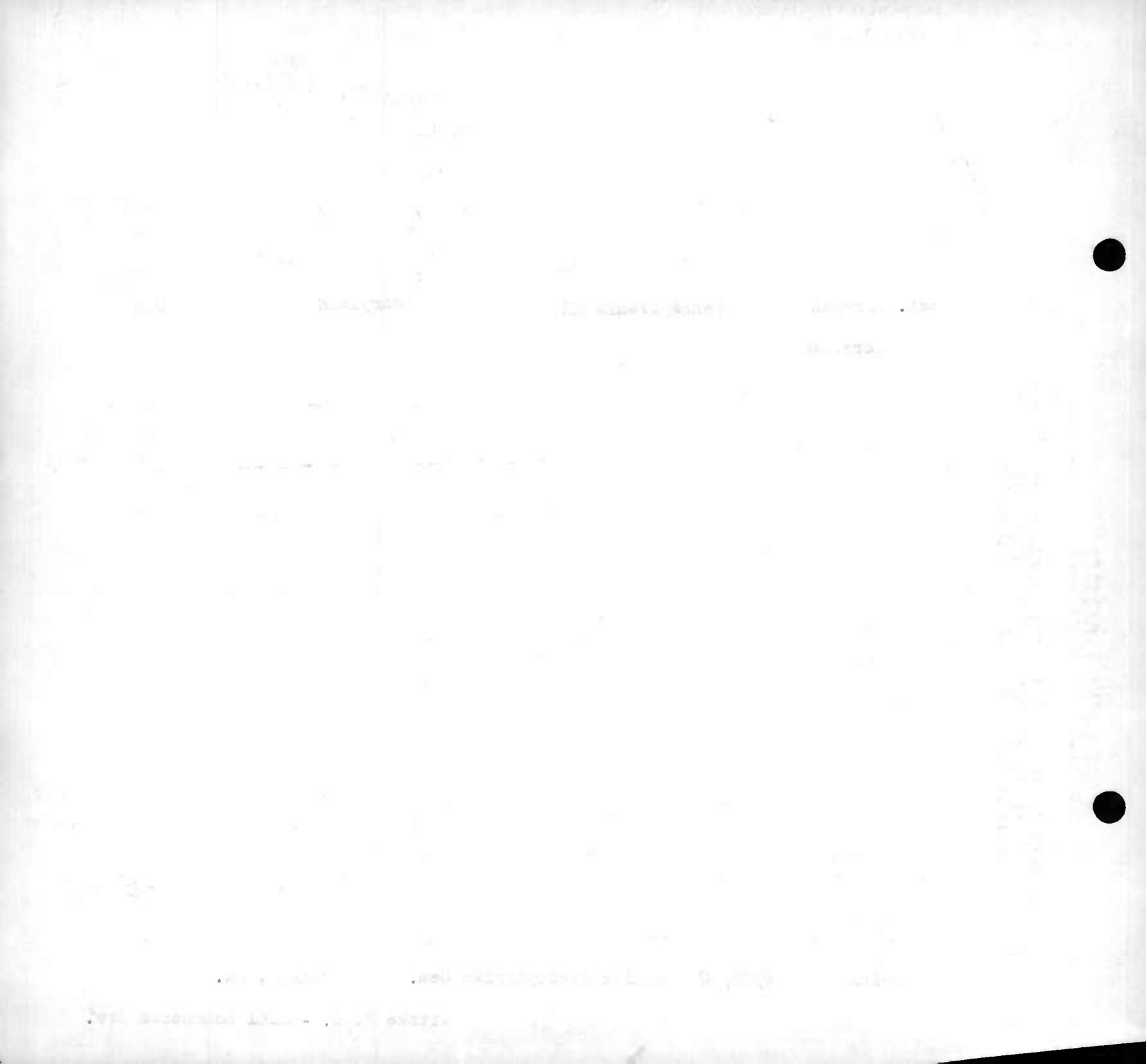
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 6112</span>	
BIRTH NO. <span style="float: right;">67 6112</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>KREUDER, Miss ANNA</b>		2. DATE AND HOUR OF DEATH <b>June 22, 1967 7<sup>40</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>13-07</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>"Keswick"</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>700 W. 40th St.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never married</b>	8. DATE OF BIRTH <b>12-28-1873</b>	9. AGE (In years last birthday) <b>93 YRS.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chocolate dipper</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland, Balto</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Kreuder</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Schomann</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-3601A</b>		17. INFORMANT <b>Grace S. McGaul R.W.</b>	
18. <b>442X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCLEROTIC cardio-vascular renal disease</b>		CAUSE OF DEATH (A) <b>ARTERIOSCLEROTIC cardio-vascular renal disease</b> (B) <b>terminal episode 2 days</b> (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-10-1965</b> to <b>6-22-1967</b> , that (I) (we) last saw the deceased alive on <b>6-22-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harold P. Biehl</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6-23-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Harold P. Biehl</b>		M.D. 23D. ADDRESS <b>700 W. 40th Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/24/67</b>	24C. NAME OF CEMETERY or CREMATORY <b>Western Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <b>R. E. E. Feltz, M.D.</b>		25C. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

(This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.)

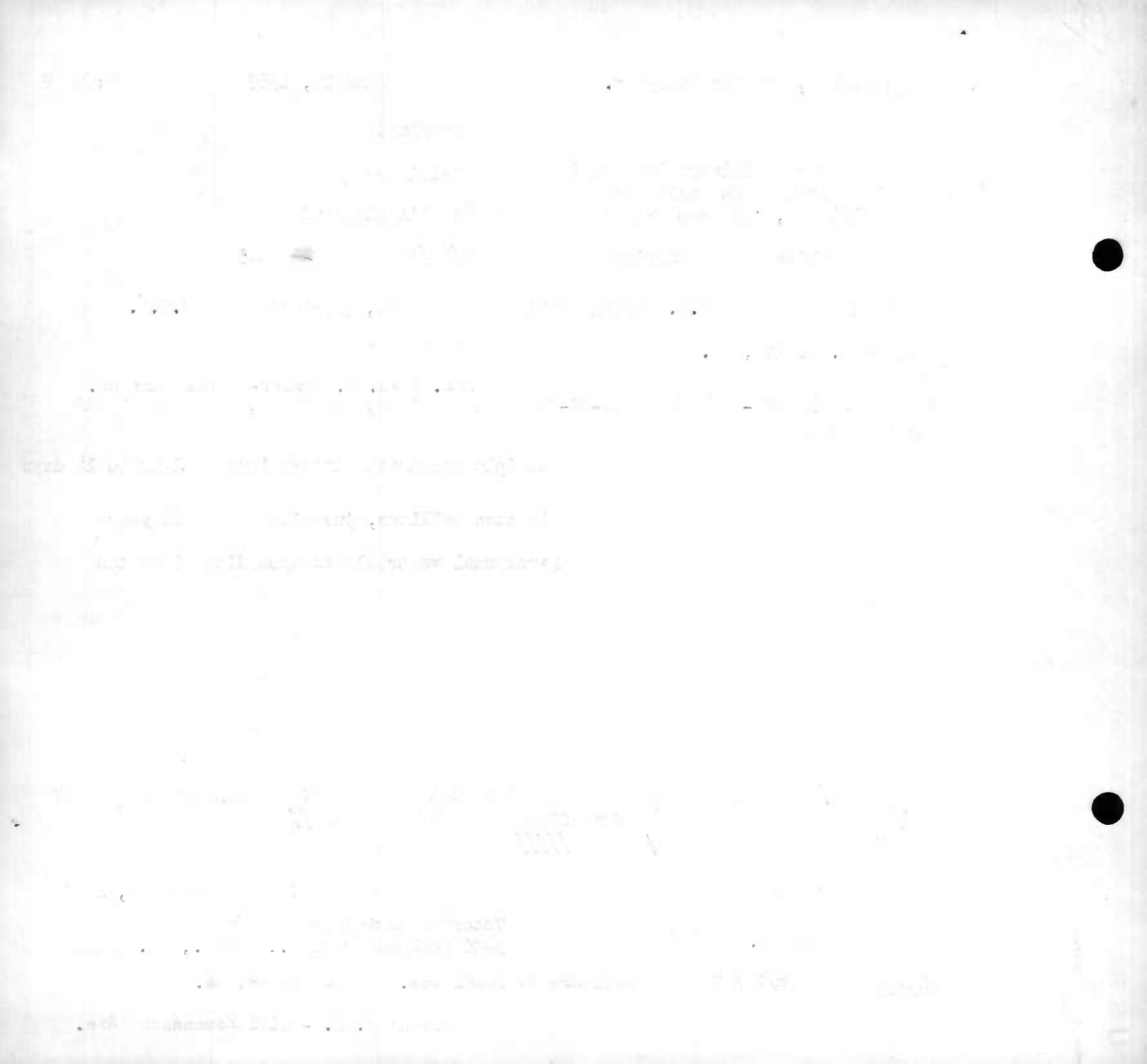
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6113</b>	
BIRTH NO. <b>67 6113</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>EDWARD GRIMES</b>		2. DATE AND HOUR OF DEATH <b>6/25/67 9 A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>28-04</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>4643 MANORDENE Rd #29</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11/16/97</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Fireman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania RR</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Lorenzo</b>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wife: Rose</b>	
				ADDRESS <b>Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Severe Congestive Heart Failure</b>		CAUSE OF DEATH (A) DUE TO <b>Coronary artery disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		years	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2/20/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/20</b> 19 <b>67</b> to <b>6/25</b> 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>6/25</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Hidalgo</b>				23B. DATE, SIGNED <b>6/25/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>EDUARDO HIDALGO</b>				23D. ADDRESS <b>Sinai Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/28/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Granite Presbyterian Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Granite, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldy</b>		25C. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Ave.</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6114</b>	
BIRTH NO. <b>67 6114</b>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>FWLER, Charles Henry Jr.</b>		2. DATE AND HOUR OF DEATH <b>June 22, 1967 9:50 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>28-04</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>46 Hillvale Road</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>6/20/22</b>	9. AGE (In years lost birthday) <b>45</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Postal Service</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Charles H. Fowler, Sr.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 10/14/42 - 7/26/44</b>		16. SOCIAL SECURITY NO. <b>216-12-0540</b>		17. INFORMANT ADDRESS <b>Mrs. Chas. H. Fowler-46 Hillvale Rd. VA Hospital, Baltimore, Maryland 21218</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Multiple myocardial infarctions</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr to 14 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Diabetes mellitus, juvenile</b>		(B) DUE TO		<b>20 years</b>	
		(C) DUE TO		<b>Paroxysmal ventricle tachycardia</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 1st 1967</b> to <b>June 22nd 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 22nd 1967</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <i>Allen D. Johnson</i>				23B. DATE SIGNED <b>June 23, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALLEN D. JOHNSON</b>		23D. ADDRESS <b>Veterans Administration Hospital 3900 Loch Raven Blvd., Balto., Md. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/26/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke F. D. - 4101 Edmondson Ave.</b>	



67 6115

BALTIMORE CITY HEALTH DEPARTMENT

67 6115

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES

KRONEBERGER

2. DATE AND HOUR PRONOUNCED DEAD

June 24, 1967

12:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

MERCY HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1838 W. Fayette Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

11/27/85

9. AGE (In years  
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW I

16. SOCIAL  
SECURITY NO.

219-18-2770

17. INFORMANT

Mrs. Christina Wise

ADDRESS

127 S. Exeter St. - 21202

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spatz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/24/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/28/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 26 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Witzke F. D. - 4101 Edmondson Ave.

ADDRESS

11/27/63

Received

Mr. Tolson

100-442800-1230  
100-442800-1230

100-442800-1230

100-442800-1230

RECEIVED  
FBI  
NOV 27 1963

100-442800-1230

100-442800-1230

100-442800-1230

100-442800-1230

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 6116	
BIRTH NO. 67 6116		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>John Kohlhepp</i> (JOHN LOUIS KOHLHEPP)		2. DATE AND HOUR OF DEATH <i>24 June 67</i> <i>850 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>MERCY HOSPITAL</i>		A. STATE <i>Md</i> B. COUNTY <i>12-03</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>2746 N. Calvert Street</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>never married</i>	8. DATE OF BIRTH <i>11 Sept. 1887</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BOOKKEEPER</i>	10B. KIND OF BUSINESS OR INDUSTRY <i>ROOFING CO.</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Anthony Kohlhepp (Baltimore)</i>		14. MOTHER'S MAIDEN NAME <i>Katharine VonDran (Baltimore)</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>217-32-8425A</i>		17. INFORMANT <i>Brother</i> ADDRESS <i>Geo. A. Kohlhepp, 2746 N. Calvert St., Balto.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Pneumonia</i>		<i>3 weeks</i>	
ANTECEDENT CAUSES		(B) <i>pulmonary emphysema</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		Arteriosclerotic Heart Disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>YES</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>June 18</i> <i>19 67</i> to <i>June 24</i> <i>19 67</i> , that (I) (we) last saw the deceased alive on <i>June 24</i> <i>19 67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Richard R Babb MD</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>24 June 67</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>6/28/67</i>	24C. NAME OF CEMETERY or CREMATORY <i>NEW CATHEDRAL</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 26 1967</i>		25B. NAME OF REGISTRAR <i>R. Taylor</i>	25C. FUNERAL DIRECTOR ADDRESS <i>Stewart &amp; Mowen Co., 108 W. North Av., City</i>		

10/10/10

11

10/10/10

10/10/10

10/10/10

10/10/10

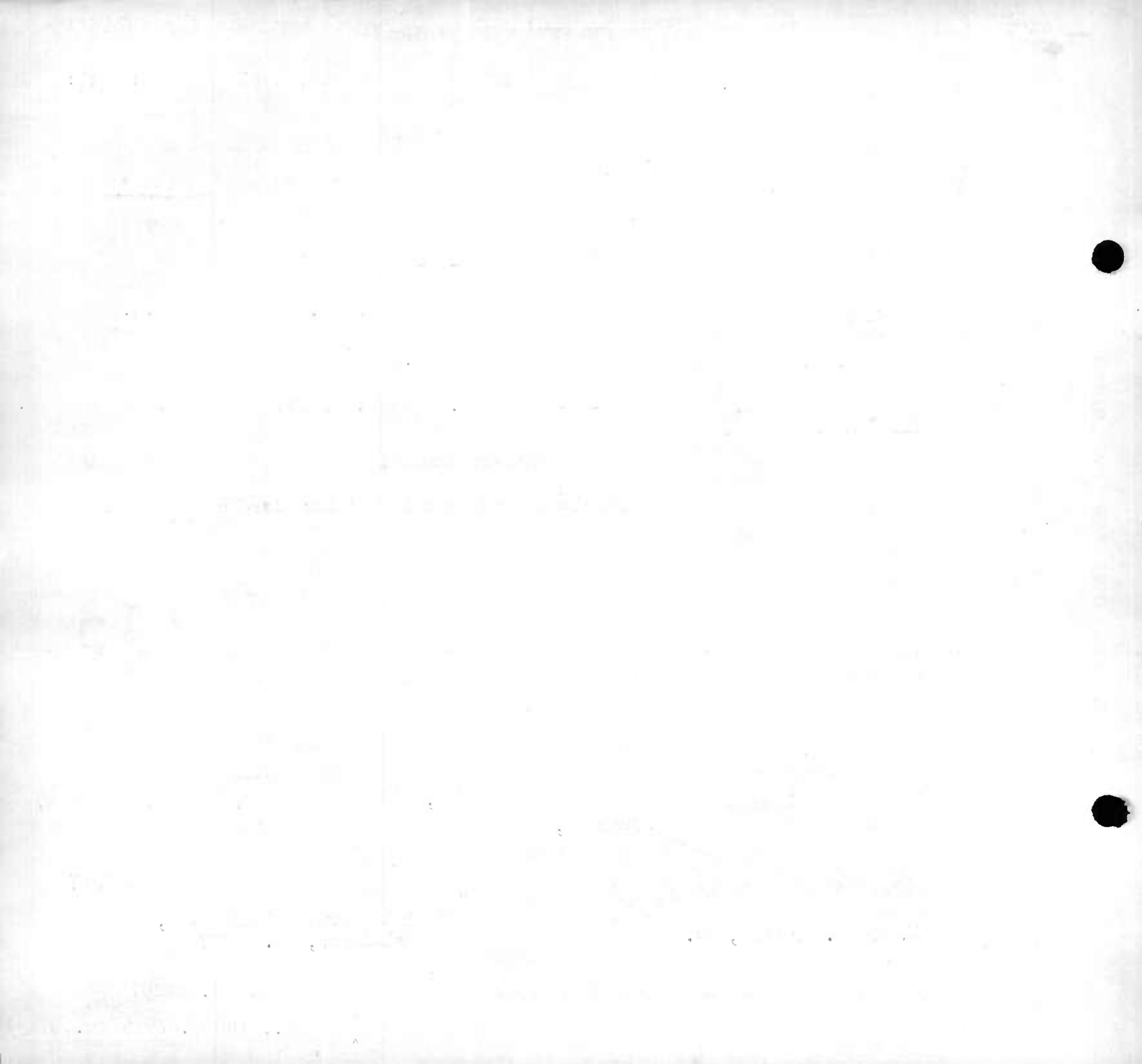
10/10/10

10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6117</b>	
BIRTH NO.		<b>67 6117</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>MRS. ADELLA DALEY RICKER</b>		<b>June 23, 1967 6:45P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <b>ROLAND VIEW TOWERS 3838 Roland Avenue</b>		A. STATE <b>Maryland</b>			
		B. COUNTY <b>13-07</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>City of Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>3838 Roland Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>Nov-12-1895</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Samuel W. T. Daley</b>		14. MOTHER'S MAIDEN NAME <b>Ida S. Robinson</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>049-30-4582</b>		17. INFORMANT ADDRESS <b>Mrs. Ruth R. Grill, Red Bank, New Jersey.</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary occlusion</b> Arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>one month</b> <b>3 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6 *****</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>*****</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>*****</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>*****</b>	
21D. TIME OF INJURY (APPROX.) <b>*****</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>*****</b>	
22. I certify that (I) <del>(the physician)</del> attended the deceased from <b>June 22, 19 67</b> to <b>June 23, 19 67</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>June 22, 19 67</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(not)</del> view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>23 June 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Millard T. Traband, Jr.</b>				23D. ADDRESS <b>1811 North Rolling Road, Baltimore, Md. 21207</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>June-26-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park</b>	
24D. LOCATION <b>Woodlawn, Md. 21207</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltman</b>	
25C. FUNERAL DIRECTOR <b>STEWART &amp; MWEN, CO., 108 W. North Av., Cityl</b>		25D. ADDRESS			





1  
S-530

67 6118

BALTIMORE CITY HEALTH DEPARTMENT

67 6118

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RICHARD

SMITH

2. DATE AND HOUR PRONOUNCED DEAD

June 24, 1967

11:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

916 E. Eager Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

916 E. Eager Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

6-15-02

9. AGE (In years last birthday)

65

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CHAUFFEUR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

RICHARD D. SMITH

14. MOTHER'S MAIDEN NAME

MARION THOMAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

HELEN SMITH 916 E. Eager St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/25/67

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

6/28/67

23C. NAME OF CEMETERY or CREMATORY

MT. CALVARY

23D. LOCATION (City, town, or county)

Q. Q. County, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 26 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Joseph E. Lock, Jr. 1304 N. Central

VALLEY BROOK

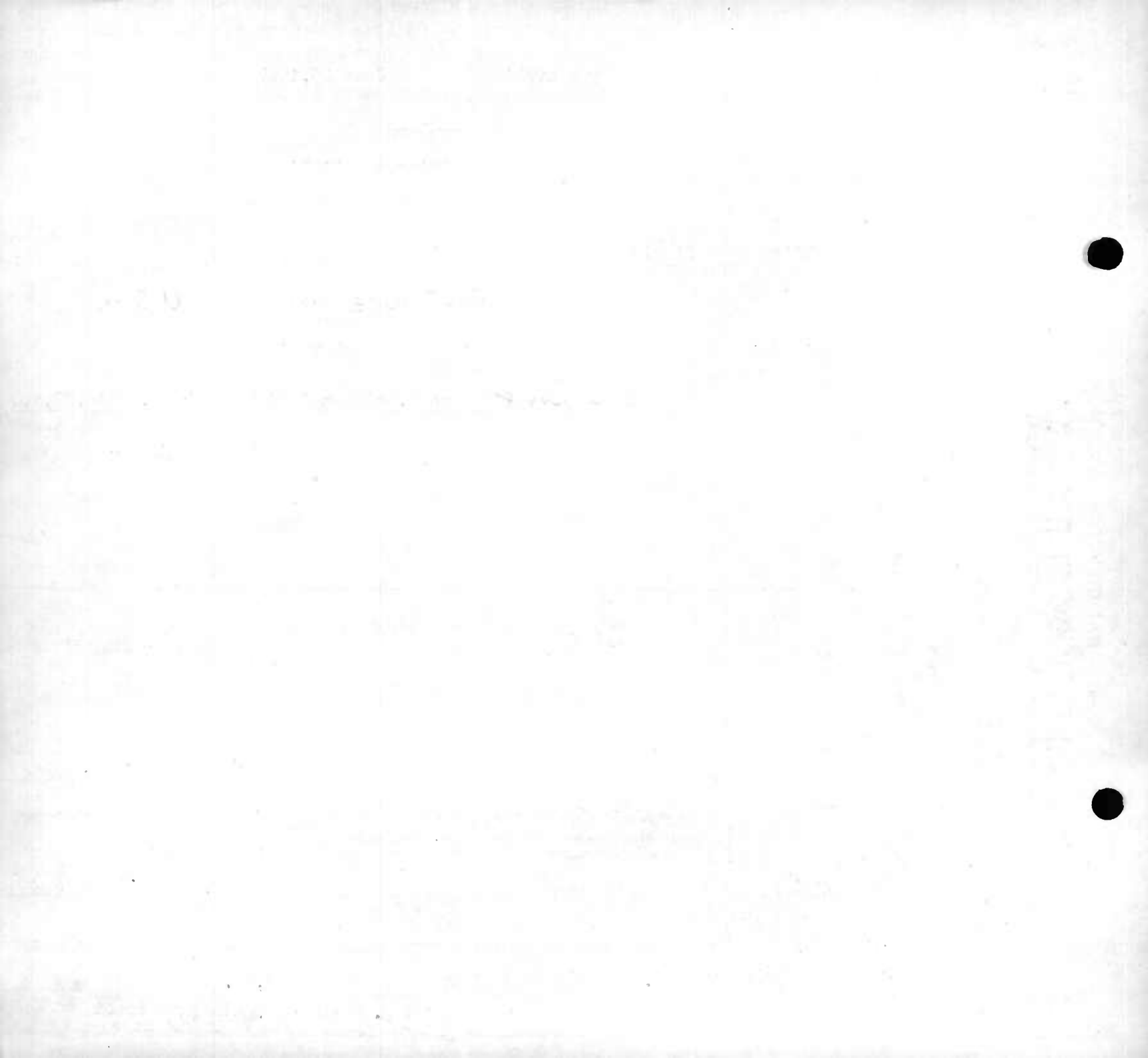
VALLEY BROOK

VALLEY BROOK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6119		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6119	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Stella Sypniewski		June 25, 1967		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
At Home 502 South Montford Ave		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore 21224			
		D. STREET ADDRESS (If rural, give location)			
		502 South Montford Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	White	Single	5/7/1898	69	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				BALTIMORE, Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John Sypniewski		Antonina Bykowski			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		215-09-4498		Herman J. Kalkowski 3407 Louth Rd. Balto, 22, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Antibiotic COI		4 + yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Chronic Lung Disease			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-63 to 6-26-67, that (I) (we) lost saw the deceased alive on 5-31-67 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Theodore T. Nizuch				6-26-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
T. T. Nizuch				429 Schenck St 21231	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/28/67		St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Baltimore, Md.		JUN 26 1967		George A. Weber	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
				George A. Weber 705 South Ann Street	



H 420

67 6120

BALTIMORE CITY HEALTH DEPARTMENT

67 6120

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH

T.

HELOWICZ

2. DATE AND HOUR PRONOUNCED DEAD

June 24, 1967

10:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Church Home Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1903 Gough Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

3/10/1918

9. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Helowicz

14. MOTHER'S MAIDEN NAME

Maryanna Wlodarczyk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

217-05-2063

17. INFORMANT

ADDRESS

Miss. Anna Helowicz 1903 Gough Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxiation, etc. It means the disease,  
injury or complication which caused death.)(A) Massive Gastrointestinal Bleeding  
originating from Peptic Duodenal  
Ulcer.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/25/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/28/67

23C. NAME of CEMETERY or CREMATORY

St. Stanislaus Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 26 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

George A. Weber 705 South Ann Street

ADDRESS

George A. Weber

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10/10/01 BY 60322 UC/NCH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 6121		67 6121	
M.E. CASE NO.		67 6121		67 6121	
1. NAME OF DECEASED (Type or Print)		THEODORE SHEPPARD		2. DATE AND HOUR OF DEATH 6/25/67 12 Noon M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		PENNsylvania	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Meyersdale	
Johns Hopkins Hospital Baltimore, Md 21205		D. STREET ADDRESS (If rural, give location)		230 LARGO STREET	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 12-2-85	9. AGE (In years last birthday) 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country) Meyersdale Pa		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME DAVID SHEPPARD	
14. MOTHER'S MAIDEN NAME Josephine Purdy		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Madeline Hurst		ADDRESS Largo		18. CAUSE OF DEATH FUO ? Malignancy	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. INTERVAL BETWEEN ONSET AND DEATH 4 mos	
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 5/12/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory Laparotomy	
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
27. DATE OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		29. HOW DID INJURY OCCUR?	
30. I certify that (I) (This hospital) attended the deceased from 4/12 1967 to 6/25 1967, that (I) (we) lost saw the deceased alive on 6/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.		31. SIGNATURE Allen Ginsberg		32. DATE SIGNED 6/25/67	
33. PHYSICIAN'S NAME (Type) ALLEN GINSBERG		34. ADDRESS JOHNS HOPKINS HOSPITAL		35. DATE OF BURIAL OR CREMATION 6/29/67	
36. NAME OF CEMETERY OR CREMATORY Union Cemetery		37. LOCATION Baltimore		38. DATE OF HEALTH DEPT. RECORD JUN 26 1967	
39. NAME OF FUNERAL DIRECTOR Meyersdale & Horne		40. ADDRESS Largo		41. DATE OF DEATH JUN 26 1967	

12-2-82 81  
230 Case Street  
Meyersdale  
Pennsylvania

Baltimore, Md 21202  
Johns Hopkins Hospital

Male Negro Single

Josephine Rudy

David S. Meigs

2/12/87 Exploration & operation 1/82



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

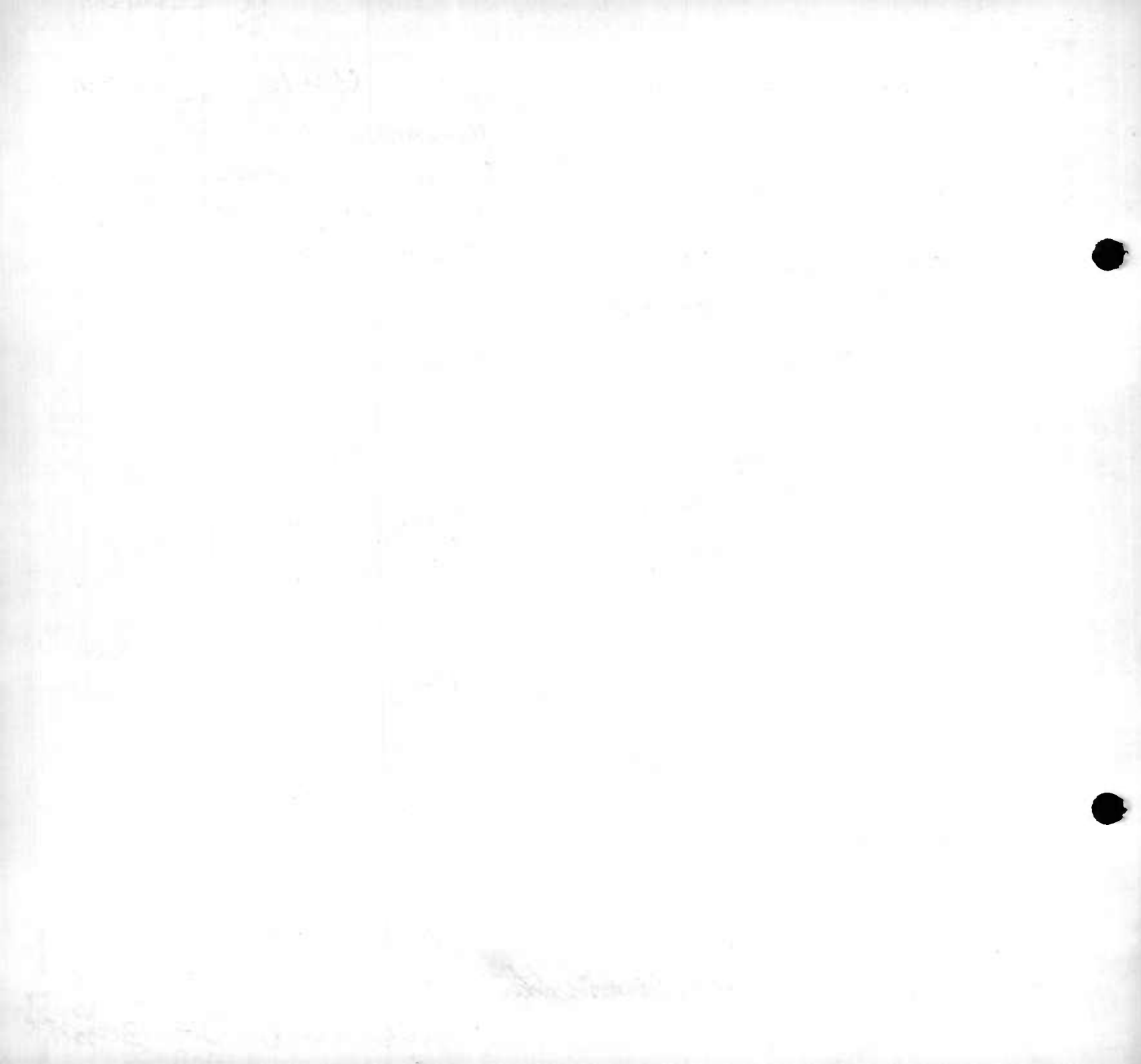
BIRTH NO. 67 6122		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6122	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Viola Fowler</i>		2. DATE AND HOUR OF DEATH <i>June 21 1967 1 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institutional: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>2020 N. Wolfe St</i>		D. STREET ADDRESS (If rural, give location) <i>2020 N. Wolfe St</i>		E. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
5. SEX <i>Female</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 9, 1904</i>	9. AGE (In years last birthday) <i>63</i>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Balto Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Henry Fisher</i>		14. MOTHER'S MAIDEN NAME <i>Elijah Brook</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-07-6682</i>		17. INFORMANT <i>Milton Fowler Same</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. If means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cerebral Thrombosis (recurrent attacks)</i> (B) <i>Marshall Hypertension</i> (C) <i>Generalized Arterio Sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs (since 1962)</i> <i>1962</i> <i>1962</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Chronic Nephritis, Hemiplegia &amp; Dysphagia</i>		19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>	
20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>None</i>		21C. HOW DID INJURY OCCUR? <i>None</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>None</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>None</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>July 20 1967</i> to <i>July 21 1967</i> and that (I) (we) last saw the deceased alive on <i>July 20 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ralph J. Young</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/23 1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>Ralph J. Young</i>		23D. ADDRESS <i>1532 E. Monument St Balto Md</i>		23E. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-26-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Balto Nat Cat</i>	
24D. LOCATION (City, town, or county) <i>Balto Md</i>		24E. STATE <i>Md</i>		24F. ADDRESS <i>1001 Brantley Ave</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 26 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fadden</i>		25C. FUNERAL DIRECTOR <i>Cheryl Wilson</i>	

$$\frac{1}{f} = \frac{1}{f_1} + \frac{1}{f_2}$$

3

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6123		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 6123	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
				Jackson Annie Lucille				6/24/67 9:30 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland				B. COUNTY	
University Hosp.				C. CITY OR TOWN Baltimore, Maryland				20-07	
				D. STREET ADDRESS (If rural, give location)					
414 N. Hilton Street									
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Female	Negro	WIDOW	5/10/36	41					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Cook		Bar & Rest.				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Thomas John				Alma Tucker					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
296X I				Intracranial hemorrhage					
ANTECEDENT CAUSES				(B) Purpura Fulminans					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Intravascular coagulopathy					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 6/16/67 to 6/24/67, and that (I) (we) last saw the deceased alive on 6/24/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Kurt P. Sligar				6/24					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Kurt P. Sligar				414 N. Hilton St.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		6-26-67		Western State Ct		Baltimore			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUN 26 1967		Robert E. Taylor, M.D.		Chap Wilson		1000 Brantley Rd			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

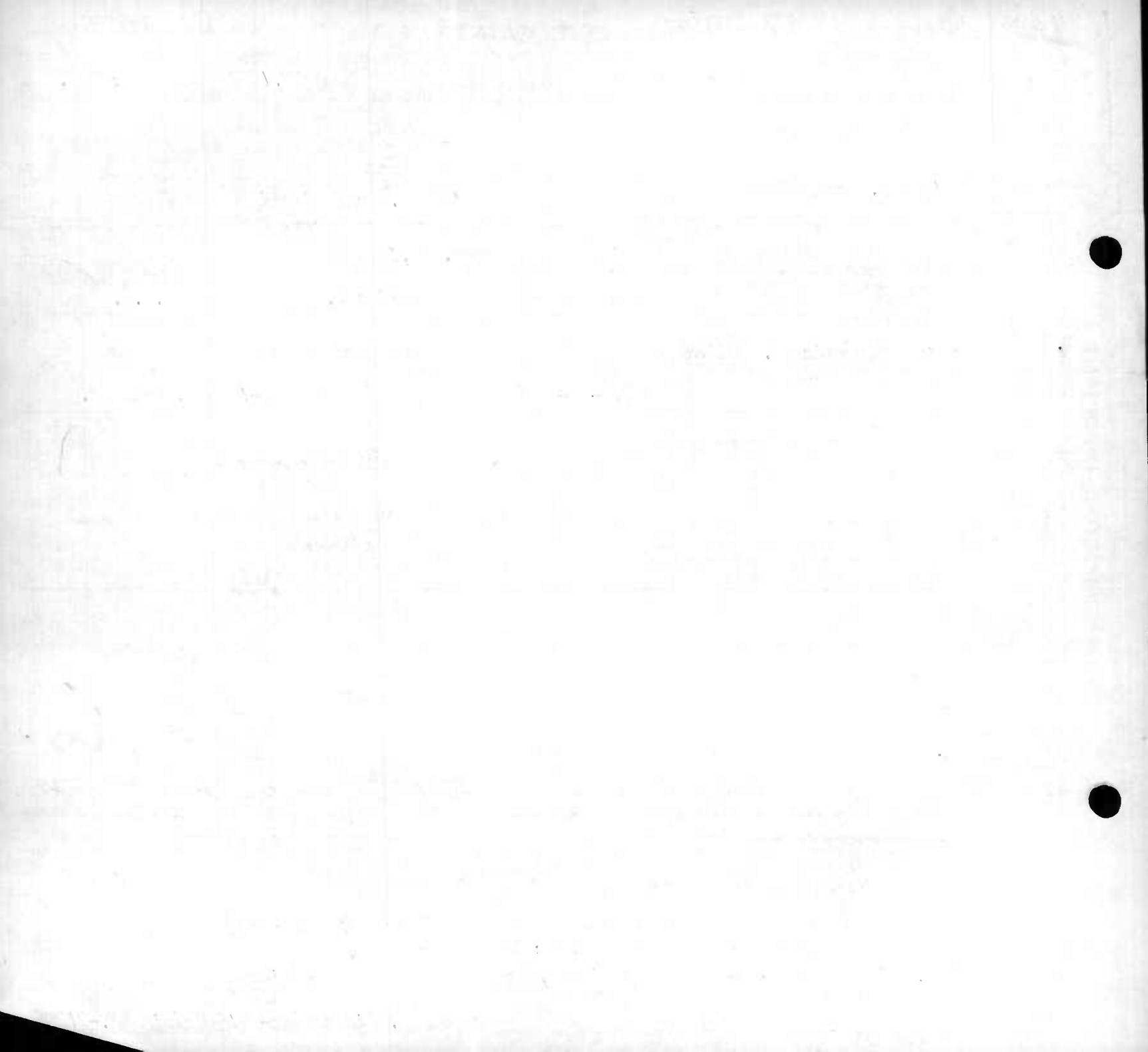
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6124	
BIRTH NO. 67 6124		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Emma May Kirby		2. DATE AND HOUR OF DEATH June 22, 1967 10.50 Am. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1305			
FULL NAME OF HOSPITAL OR INSTITUTION 3108 Keswick Road		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3108 Keswood Road KESWICK Rd.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/15-1909	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John Cromwell			
14. MOTHER'S MAIDEN NAME Lockner		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-03-4205		17. INFORMANT ADDRESS Louis L. Kirby 3108 Keswick Road			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Mixed hemorrhoidal gland tumor DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 8 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 1967 to June 19 1967, that (I) (we) last saw the deceased alive on June 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sheldon Goldbeier M.D.		23B. DATE SIGNED June 23, 1967		23C. PHYSICIAN'S NAME (Type) SHELDON GOLDBEIER, M.D.	
23D. ADDRESS 848 W. 36th Street		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 6/26, 1967		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Frank J. Seitz 814 W. 36th St	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

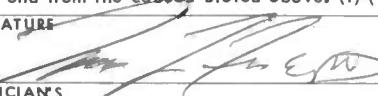
BIRTH NO. <span style="font-size: 2em;">67 6125</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 2em;">67 6125</span>	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">George John Walter</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">June 23, 1967</span> <span style="float: right;">9:30 P. M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">1620 N. Port Street</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">8-02</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">1620 N. Port Street</span>		
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Nov. 22, 1898</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">68</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Clerk</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Produce Market</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">Frederick J. Walter</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Margaret Rudroff</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-03-5595</span>			17. INFORMANT <span style="font-size: 1.2em;">Amy Spangler Walter - 1620 N. Port St.</span>		
18. <span style="font-size: 1.5em;">443X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Cerebral Hemorrhage</span> DUE TO (B) <span style="font-size: 1.2em;">Hypertension cardiovascular disease</span> DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1 yr.</span> <span style="font-size: 1.2em;">10 yrs</span>			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">none</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">no</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">April</span> 19 <span style="font-size: 1.2em;">66</span> to <span style="font-size: 1.2em;">June</span> 19 <span style="font-size: 1.2em;">67</span> , that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">6-22</span> 19 <span style="font-size: 1.2em;">67</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">J. DUBR MOORES</span>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">6-24-67</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">J. DUBR MOORES</span>			23D. ADDRESS <span style="font-size: 1.2em;">3105 BELAIR RD.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">6-27-67</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Cemetery</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 26 1967</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">c John C. Miller Inc-6415 Belair Rd</span>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67-11988 67 6126		CERTIFICATE OF DEATH X		Registered No. 67 6126	
1. NAME OF DECEASED (Type or Print) <b>BABY Boy King</b>				2. DATE AND HOUR OF DEATH <b>6/23/67 7:30 PM.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinai Hospital BALTO. MD</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO 33-00</b> D. STREET ADDRESS (If rural, give location) <b>2012 RUSSELL AVE Sinai Hospital 21207</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Child</b>		8. DATE OF BIRTH <b>6/19/67</b>	9. AGE (In years last birthday) <b>2 4</b>	If Under 1 Yr. Months Days Hours		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William King</b>				14. MOTHER'S MAIDEN NAME <b>Anna King</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT ADDRESS <b>William King 2012 Russell Ave 21207</b>			
18. <b>773.5 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Transected Hyaline Membrane Disease</b>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>Heb. Transected Birth wt 1755</b>					
(C) _____									
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>									
19A. DATE OF OPERATION <b>6/23/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <del>(1)</del> (this hospital) attended the deceased from <b>June 19 1967</b> to <b>June 23 1967</b> , that (1) (we) lost saw the deceased alive on <b>June 23 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/24/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>Louis L. Fine, M.D.</b>		23D. ADDRESS <b>Sinai Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/26/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olive</b>		24D. LOCATION (City, town, or county) (State) <b>Randallstown Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>6/26/67</b>		25B. NAME OF REGISTRAR <b>John T. Stansbury</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John T. Stansbury 6419 Windsor Mill</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6127	
BIRTH NO. 67 6127		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN THOMAS WEAVER</b>		2. DATE AND HOUR OF DEATH <b>JUNE 21, 1967 5:55 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVENUE BALTO. 29, MARYLAND</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>1401 NORTH ROLLING RD.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>4/24/10</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POLICEMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BALTO. CITY POLICE</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ALBERT</b>			
14. MOTHER'S MAIDEN NAME <b>ROSANNA (GALLAGHER)</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>215-01-6310</b>		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AV</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>163X-260X</b>		CAUSE OF DEATH (A) <b>Cardiac Decompensation</b> DUE TO (B) <b>Metastatic Cancer</b> DUE TO (C) <b>Pulmonary Carcinoma</b>			
INTERVAL BETWEEN ONSET AND DEATH		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus</b>			
19A. DATE OF OPERATION <b>6/4/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Thoracotomy Tube</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JUNE 4</b> 19 <b>67</b> to <b>JUNE 21</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>JUNE 21</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Frank M. Detone</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>		23D. ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-24-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Agnes Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Taylor, Corcoran &amp; Co., Catonsville, Md.</b>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6128</b>	
BIRTH NO. <b>67 6128</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Hanna (NMN) Anderson</b>		2. DATE AND HOUR OF DEATH <b>June 21, 1967 8:00P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hosp</b> <b>Baltimore City Hospital D.O.A.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Jones Creek 21219</b>		D. STREET ADDRESS (If rural, give location) <b>7200 North Dakota Avenue</b>	
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED <b>widowed</b>	8. DATE OF BIRTH <b>April 22, 86</b>	9. AGE (In years last birthday) <b>81</b>	10. CITIZENSHIP <b>USA</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Joseph C. Hale</b>		14. MOTHER'S MAIDEN NAME <b>Ida Emberg</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>190-05-7502</b>		17. INFORMANT ADDRESS <b>Ray Persuhn 96 Wise Avenue Baltimore 21222</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.) <b>Anteroseclerotic Heart Disease</b>		CAUSE OF DEATH (A) DUE TO <b>Anteroseclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>Diabetes mel</b>		<b>?</b>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1966</b> to <b>June 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 18, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. B. Herman</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>R. B. Herman</b>		23D. ADDRESS <b>5510 Roland Ave 21215 Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/26/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Grand View Cemetery</b>	
24D. LOCATION <b>Johnstown, Pennsylvania</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <b>Walter E. Taylor M.D.</b>		25C. FUNERAL HOME <b>Walter Brooks Bradley, Inc., Dundalk</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6129</b>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <b>67 6129</b></p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>REV. ANTONIO OSCAR DFAULT</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <b>6-23-67 4:40 A.M.</b></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="text-align: center;"><b>SETON PSYCHIATRIC INSTITUTE</b></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>MASSACHUSETTS</b></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>HOLYOKE</b></p> <p>D. STREET ADDRESS (If rural, give location) <b>271 CHESTNUT STREET</b></p>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>5-28-00</b>	9. AGE (In years last birthday) <b>67</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRIEST</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>	11. BIRTHPLACE (State or foreign country) <b>MASSACHUSETTS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>STEPHEN DFAULT</b>			14. MOTHER'S MAIDEN NAME <b>ALMA KASKAY</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>??</b>		16. SOCIAL SECURITY NO. <b>028303890</b>	17. INFORMANT ADDRESS <b>Records Seton Institute, Baltimore 21215</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL THROMBOSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CEREBRAL AND GENERAL ARTERIOSCLEROSIS MYOCARDIAL DEGENERATION</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 YEARS</b>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>PSYCHOTIC DEPRESSIVE REACTION</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>December 1, 1966</u> to <u>June 23, 1967</u> . that (I) (we) last saw the deceased alive on <u>June 22, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Walter O. Jahrreiss</i>				23B. DATE SIGNED <b>June 23, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>WALTER O. JAHRREISS</b>		23D. ADDRESS <b>6420 REISTERSTOWN RD., BALTIMORE, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>June-27-67</b>	24C. NAME of CEMETERY or CREMATORY <b>Holy Rosary-St. Mary's</b>	24D. LOCATION (City, town, or county) (State) <b>Spencer, Mass.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>	25C. FUNERAL DIRECTOR ADDRESS <b>Stewart &amp; Mowen Co 108-W-North-Av 21201</b>		

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6130</b>	
BIRTH NO. <b>67 6130</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WEHN, Osmond G.</b>		2. DATE AND HOUR OF DEATH <b>June 21, 1967 5:48 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>500 Dunkirk Rd.</b>		5. SEX <b>Male</b> 6. RACE <b>Caucasian</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never Married</b>			
8. DATE OF BIRTH <b>1-11-96</b> 9. AGE (In years lost birthday) <b>71</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 5-14-18 to 7-10-19</b>		16. SOCIAL SECURITY NO. <b>217-54-9833</b>		17. INFORMANT <b>Records</b> ADDRESS <b>21218 Veterans Administration Hospital, Balto., Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) <b>Obstruction of common bile duct calculus</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 21, 1967</b> to <b>June 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald H. Hooker</b>				23B. DATE SIGNED <b>June 23, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>DONALD H. HOOKER</b>		23D. ADDRESS <b>Veterans Administration Hospital 3900 Loch Raven Boulevard, Balto., Md 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-26-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>			
25B. NAME OF REGISTRAR <b>Wm. E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>8521 Loch Raven Blvd. Balto. Md. 21204</b>			

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# FUNERAL DIRECTOR: IMPORTANT

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F. 622		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 6131</b>	
BIRTH NO. <b>66-21235 67 6131</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JERRY FERGUSON</b>		2. DATE AND HOUR OF DEATH <b>6-20-67 10:01A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2032 VAILTHORN ROAD</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>10-6-66</b>	9. AGE (In years lost birthday) <b>8</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>	
13. FATHER'S NAME <b>JAMES FERGUSON</b>		14. MOTHER'S MAIDEN NAME <b>FAYE ADAMS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>PARENTS</b> ADDRESS <b>ABOVE</b>	
18. <b>344.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <b>Acute Hydrocephalus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>one month</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-0-</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-16-</b> 19 <b>67</b> to <b>6-20-67</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-19-67</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>Margaret E. Lang MD</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-20-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARGARET E. LANG</b>		23D. ADDRESS M.D. <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/23/67</b>		24C. NAME of CEMETERY or CREMATORY <b>OAK LAWN</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <b>Debra E. Taylor, MA</b>		25C. FUNERAL DIRECTOR <b>CORNELLY SONS</b> ADDRESS <b>300 MACE</b>	

Mother Wanda Faye Adams  
Child Jerry Wayne

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BALTIMORE CITY HEALTH DEPARTMENT

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HENRY

A.

ENGLES

2. DATE AND HOUR PRONOUNCED DEAD

June 20, 1967

11:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

42 S. KOSSMUTH STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

42 S. Kossmuth Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

JAN. 27, 1913

9. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

ATTENDANT

10B. KIND OF BUSINESS OR INDUSTRY

HOSPITAL

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Lawrence W. Engles

14. MOTHER'S MAIDEN NAME

Bess Fowler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

220-22-1627

17. INFORMANT

ADDRESS

Wm. Dorothy Shannon - 42 S. Kossmuth St.

18.

1419

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinoma of Tongue  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/21/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6-24-67

23C. NAME of CEMETERY or CREMATORY

St. Johns Cem.

23D. LOCATION

(City, town, or county)

Westminster, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Tracy Corraugh, J.A. Cataville, Inc.

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11/11/01 BY 60322 UCBAW

11/11/01

N 242

67 6133

BALTIMORE CITY HEALTH DEPARTMENT

67 6133

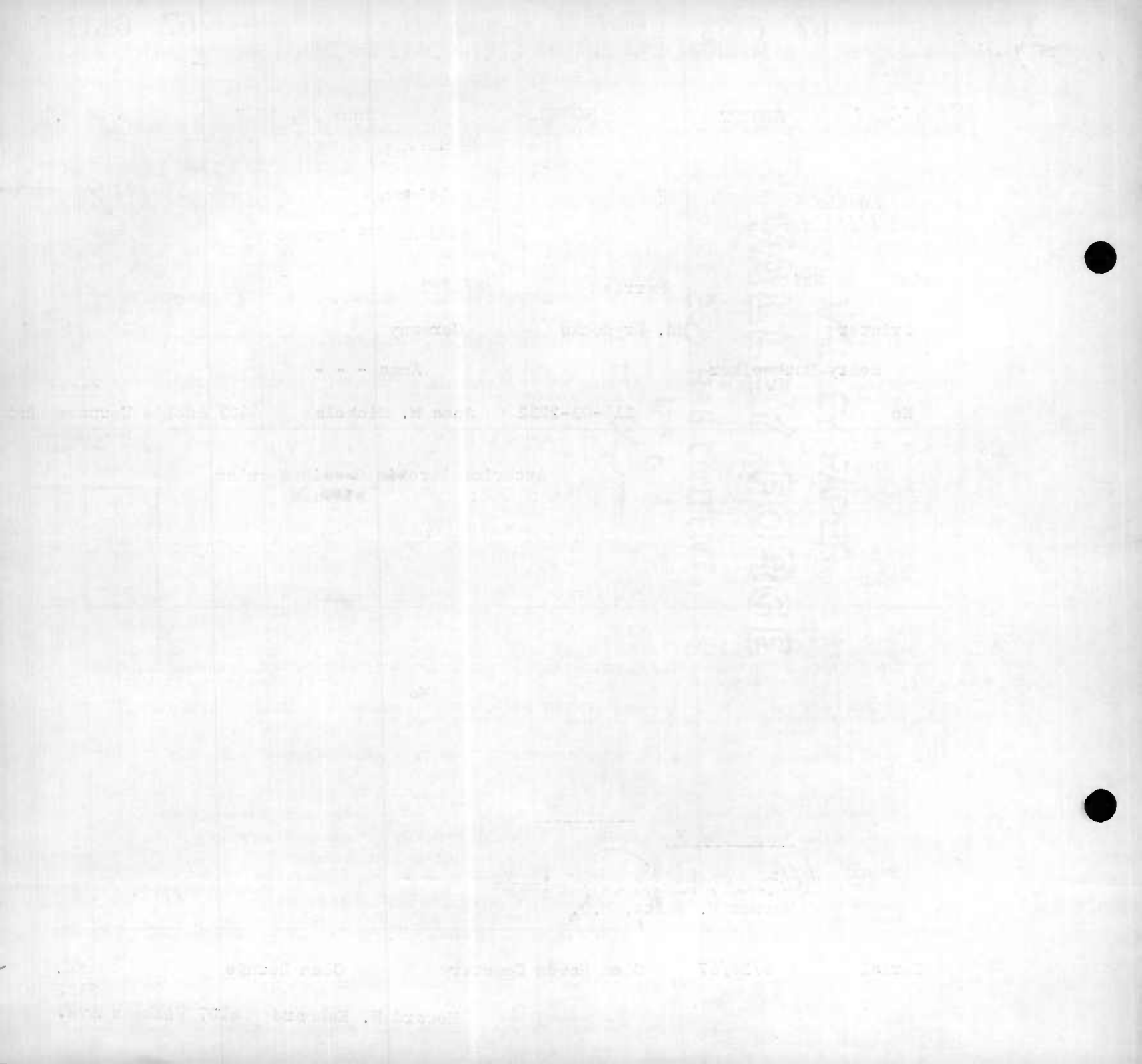
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>ALBERT AUGUST NICKELS</b>			2. DATE AND HOUR PRONOUNCED DEAD <b>June 23, 1967 8:20 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Adelle 4403 Adelle Terrace</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4403 Adelle Terrace</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>8/1/92</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Md. Drydocks</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Henry Huthwelker</b>			14. MOTHER'S MAIDEN NAME <b>Anna - - -</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-03-2232</b>		17. INFORMANT <b>Anna M. Nickels</b>	
			ADDRESS <b>21229 4403 Adelle Terrace</b>		

MEDICAL CERTIFICATION	18. CAUSE OF DEATH <b>4-22-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH	
	19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
	21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
	21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
	22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
	ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/24/67</b>		
	EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
	23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>6/26/67</b>	23C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Glen Burnie Md.</b>	
	24A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Fairley</b>		24C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 6134</span>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 67-12430</span> <span>67 6134</span> </div> <div style="text-align: center;"> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> </div>					
<div style="display: flex; justify-content: space-between;"> <div> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>Digelman, Baby Boy</i></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <i>6-24-67 8:40 P.M.</i></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <div style="display: flex; justify-content: space-between;"> <div> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><i>THE UNION Memorial Hosp</i></p> </div> <div> <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <i>MD</i> B. COUNTY <i>26-02</i></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i></p> <p>D. STREET ADDRESS (If rural, give location) <i>5706 PLAINFIELD AVE</i></p> </div> </div>					
<p>5. SEX <i>M</i></p>		<p>6. RACE <i>Can</i></p>		<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>SINGLE</i></p>	
<p>8. DATE OF BIRTH <i>6-24-67</i></p>		<p>9. AGE (In years last birthday) <i>1</i></p>		<p>If Under 1 Yr. Months: Days: Hours: Min. <i>1 20</i></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <i>None</i></p>		<p>11. BIRTHPLACE (State or foreign country) <i>MD</i></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>					
<p>13. FATHER'S NAME <i>BERNARD Digelman</i></p>			<p>14. MOTHER'S MAIDEN NAME <i>Magdalene Korowski</i></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>		<p>16. SOCIAL SECURITY NO. <i>No</i></p>		<p>17. INFORMANT <i>MOTHER</i></p>	
<p>18. CAUSE OF DEATH</p> <div style="display: flex; justify-content: space-between;"> <div> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div> <p>(A) DUE TO <i>Erythroblastosis Fetalis</i></p> <p>(B) DUE TO _____</p> <p>(C) DUE TO _____</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH <i>The 20 min's</i></p> </div> </div>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>None</i></p>					
<p>19A. DATE OF OPERATION <i>None</i></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i></p>		<p>20A. AUTOPSY? (Yes or No) <i>No</i></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i></p>					
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>No</i></p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>No</i></p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>No</i></p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? <i>No</i></p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>6-24 7:20 PM 1967</i> to <i>6-24 8:40 PM 1967</i> that (I) <del>was</del> lost saw the deceased alive on <i>6-24 1967</i> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.</p>					
<p>23A. SIGNATURE <i>Parker</i></p>				<p>23B. DATE SIGNED <i>6-24-67</i></p>	
<p>23C. PHYSICIAN'S NAME (Typed) <i>PARKER</i></p>				<p>23D. ADDRESS <i>THE UNION Memorial Hospital</i></p>	
<p>24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>24B. DATE <i>6/26/67</i></p>		<p>24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial Cemetery</i></p>	
<p>24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i></p>					
<p>25A. DATE REC'D BY HEALTH DEPT. <i>JUN 26 1967</i></p>		<p>25B. NAME OF REGISTRAR <i>Robert E. Jackson</i></p>		<p>25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i></p>	

Site Location  
Description

Notes on Kerosene  
Motor

Remarks  
No  
No

THE CIVIL ENGINEERING

1917

Copyright

1917

Released by 7M (As in them) 6-22-67 (3A) 420

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6135				BALTIMORE CITY HEALTH DEPARTMENT				WALSH, CHARLES Eugene 44			
M.E. CASE NO.				REGISTERED No. 44 6135				67 6135			
1. NAME OF DECEASED (Type or Print) <b>Walsh, Charles Eugene</b>				2. DATE AND HOUR OF DEATH <b>6/20/67 1:05 A.M.</b>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital</b>				4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>SP3</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Springfield State Hosp.</b>			
5. SEX <b>M</b>				6. RACE <b>W</b>				7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Arthur A. Walsh</b>				14. MOTHER'S MAIDEN NAME <b>Adelaide Mne Jüngling</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-18-4064</b>				17. INFORMANT <b>Chart</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO <b>Septic Shock</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.)				(B) DUE TO <b>Urinary retention</b>				<b>40 hrs.</b>			
				(C) <b>infection</b>				<b>48 hrs.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>Multiple sclerosis + paraplegia</b>							
19A. DATE OF OPERATION <b>6/22/67</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6/19/67</b> to <b>6/22/67</b> , that (I) (we) lost the deceased on <b>6/22/67</b> and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Peter S. Macnamay</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED <b>6/22/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>Peter S. Macnamay</b> M.D.								23D. ADDRESS <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>6-24-67</b>				24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer</b>			
24D. LOCATION (City, town, or county) <b>Baltimore Maryland</b>				24E. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>				24F. NAME OF REGISTRAR <b>Robert E. Taylor</b>			
24G. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>				24H. ADDRESS <b>5305 Harford Road</b>							



B-624

67 6136

BALTIMORE CITY HEALTH DEPARTMENT

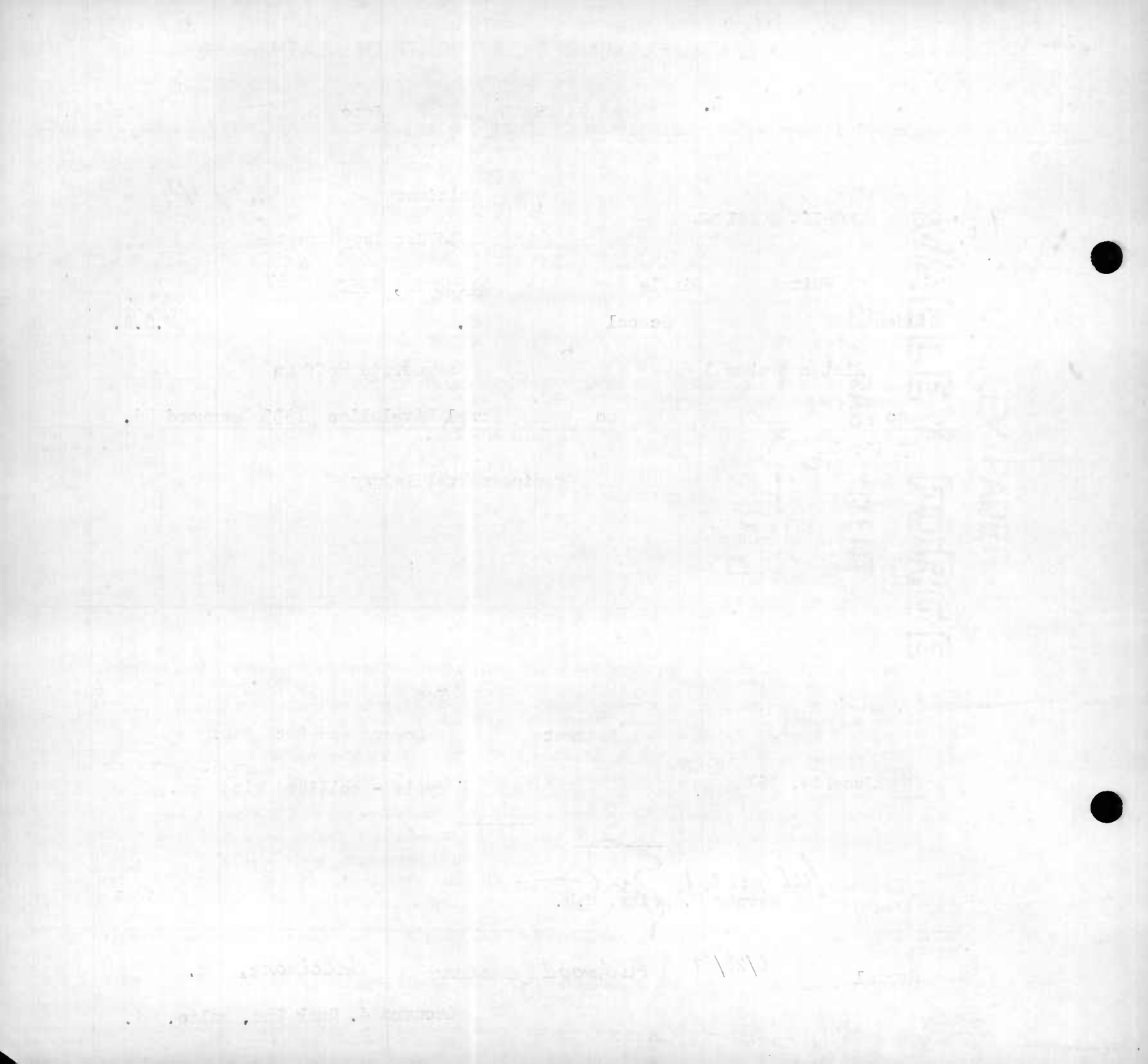
67 6136

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

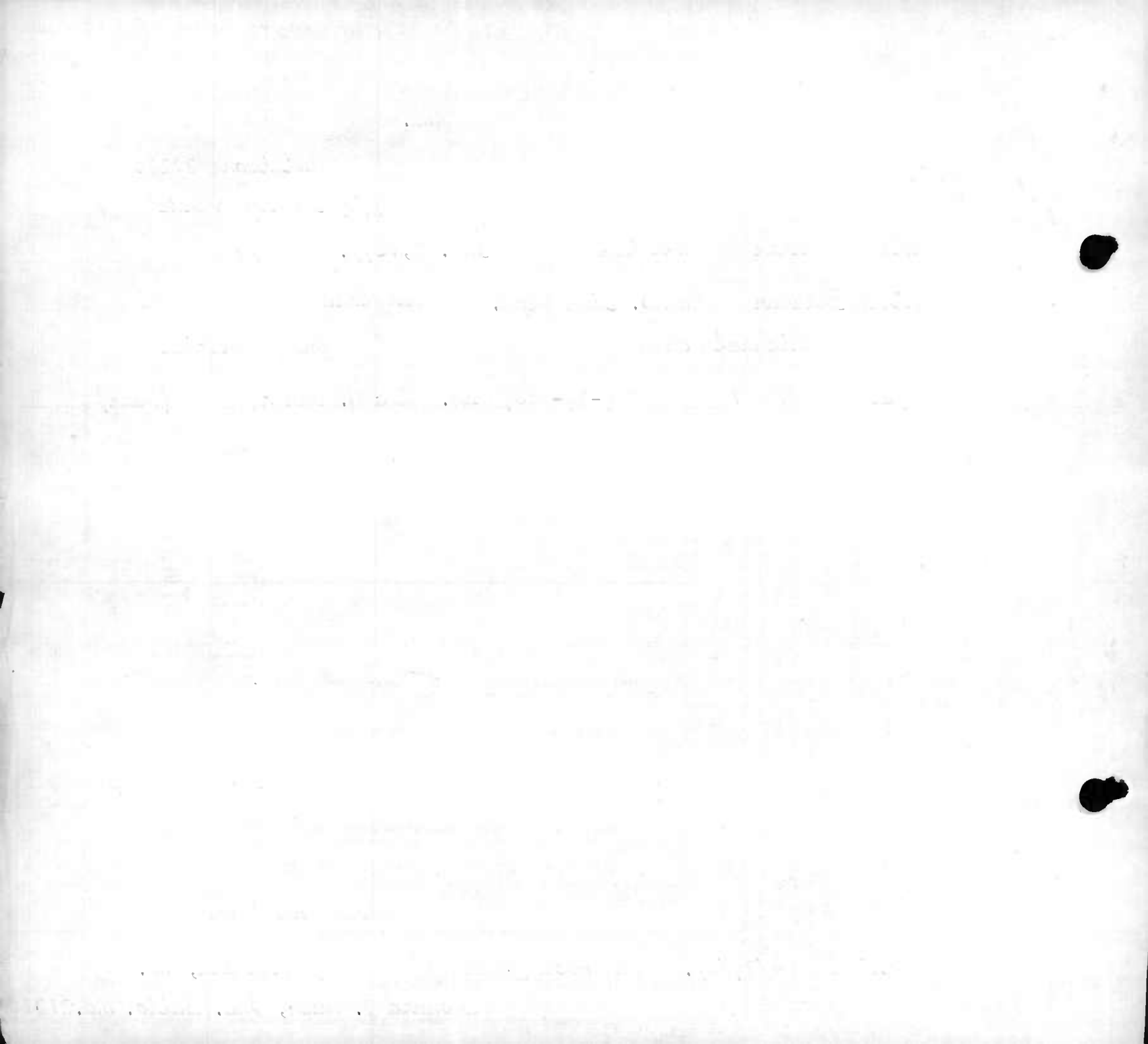
1. NAME OF DECEASED (Type or Print) <b>ALSTON</b>		L. <b>BRAKEALL</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>June 25, 1967</b> <b>4:45 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3035 Barclay Street</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>March 21, 1950</b>	9. AGE (in years last birthday) <b>17</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Alston Brakeall</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			14. MOTHER'S MAIDEN NAME <b>Marguerite Hoffman</b>		
16. SOCIAL SECURITY NO. <b>no</b>			17. INFORMANT ADDRESS <b>Ersel Divelbliss 1333 Deanwood Rd.</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Craniocerebral Injury</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Howard and 24th Sts.</b>	
21D. TIME OF INJURY (APPROX.) <b>June 24, '67 8:40 p.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>subj. operator of motor-cycle - collided with car.</b>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/25/67</b>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>6/28/67</b>		23C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		24C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6137</b>	
BIRTH NO. <b>67 6137</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>EDWARD F. SAUER</b>		2. DATE AND HOUR OF DEATH <b>6-25-67 10:40 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>37 Mercy Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>26-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21206</b> D. STREET ADDRESS (If rural, give location) <b>4423 Furley Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>Married</b>	8. DATE OF BIRTH <b>Feb. 2, 1897.</b>	9. AGE (In years lost birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Fireman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Fire Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Michael Sauer</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ronspies</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>214-24-3889</b>		17. INFORMANT <b>Mrs. Alma A. Sauer</b> ADDRESS <b>(Same)</b>	
18. <b>7-20-1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial infarction mins</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-21-67</b> 19 to <b>6-25</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-25</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edson Leon Sawbahu</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>6-25-67</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. <b>Mercy Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/29/67.</b>	24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 26 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Sauer</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	

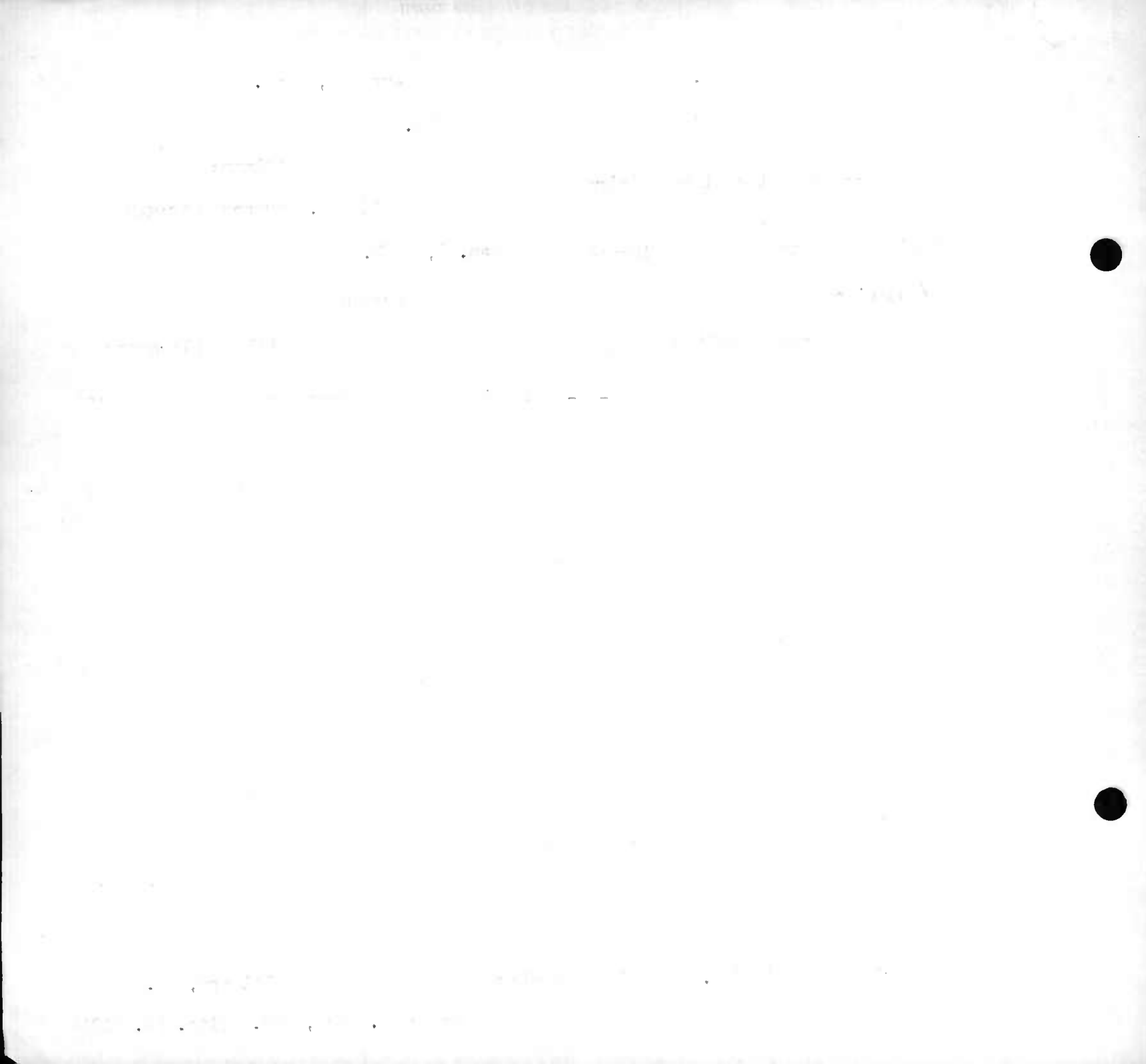




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6138				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6138	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
ANNE V. BALSTER				2. DATE AND HOUR OF DEATH June 23, 1967. 8:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
House in the Pines Belaire				Md. 27-38			
5. SEX Female				6. RACE White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
Widowed				Jan. 2, 1887.			
9. AGE (in years lost birthday)				10. AGE (in years lost birthday)			
80				80			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Maryland				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Ernest Voelker				Matilda Collenberg			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				220-44-6661			
17. INFORMANT				ADDRESS			
Miss Eleanor Etheridge				(Same)			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Due to			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				Palsy, heart Bronchiogenic Carcinoma 6 months			
ANTECEDENT CAUSES				(B) Due to			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Hypertensive arteriosclerosis heart disease			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
Duodenal ulcer							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 1967 to June 25-67, that (I) (we) last saw the deceased alive on June 25, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
George McLean				June 25/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
GEORGE M'LEAN				705 Met Act Rd			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				6/27/67.			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Woodlawn Cemetery				Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
JUN 26 1967				Leonard J. Ruck, Inc. Balto. Md. 21214			
25C. FUNERAL DIRECTOR				ADDRESS			



W 412

67 6139

BALTIMORE CITY HEALTH DEPARTMENT

67 6139

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPHINE

WIELEPSKI

2. DATE AND HOUR PRONOUNCED DEAD

June 24, 1967

12:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2208 Gough Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2208 Gough Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

FEB 28 1904

9. AGE (In years  
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

TRAUSE Clothing

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Joseph Kucharek (Deceased)

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

60

17. INFORMANT

EUGENE WIELEPSKI SHANNON DRIVE

ADDRESS 3853

18. i

422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/25/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 6140				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6140	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Elsie M. Baker</u>				6-24-67 12:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secours Hospital</u>				A. STATE <u>Maryland</u>			
				B. COUNTY <u>Balto</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>736 Charing Cross Rd</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>6-8-86</u>	9. AGE (In years, lost birthday) <u>81</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emedick Young</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE GRUBER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-20-7348A</u>		17. INFORMANT <u>BEATRICE SCHISSLER</u>		ADDRESS <u>736 CHARING CROSS RD</u>	
18. <u>200.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Lymphosarcoma, involving peripancreatic + para-gastric lymph nodes</u>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (it) (this hospital) attended the deceased from <u>6/13</u> 19 <u>67</u> to <u>6/24</u> 19 <u>67</u> , that (it) (we) last saw the deceased alive on <u>6/24</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (It) (We) (did not) view the body after death.							
23A. SIGNATURE <u>Lope T. Villafra, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/24/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lope T Villafra Jr.</u>				23D. ADDRESS <u>Bon Secours Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-27-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>WOODLAWN CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 26 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>JOHN M. WEBER &amp; SONS INC</u>			
				ADDRESS <u>401 S. CHESTER ST</u>			

1954

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6141	
BIRTH NO.		67 6141		CARR, Frank	
M.E. CASE NO.					
1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH			
(Type or Print) Carr, Frank		3:00 Am, June 24, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
U.S. P.H.S. Hospital 31 st St. & Wyman Ct. Dr. Baltimore, Md.		5353 Gulf Blvd. St. Petersburg Beach, Florida			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED	
Male		White		WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Jan. 10, 1902		65		10A. H. Blum (Messman)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Pa.		U.S.A.		Charles Carr	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Latitia Peak		USA 1940-1945		161 10 5452	
17. INFORMANT		ADDRESS			
Anna Carr (wife)		Same as patient			
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Acute Renal Tubular Necrosis			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Chronic Nutritional Cirrhosis Post total laryngectomy Prostatic Carcinoma, Chronic cystitis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
no					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3-10-67 to 6-24-67, that (I) (we) last saw the deceased alive on 6-24-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Gerald Vermeulen		6-24-67		Gerald Vermeulen, M.D. O.D.	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)			
U.S. P.H.S. Hospital, Baltimore, Md., 21211		Removal			
24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
6/24/67		Mt. Moriah		Philadelphia, Pa.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 26 1967		Robert E. Talley		Wm. J. Zickner Sons North and Aves Balto, Md.	

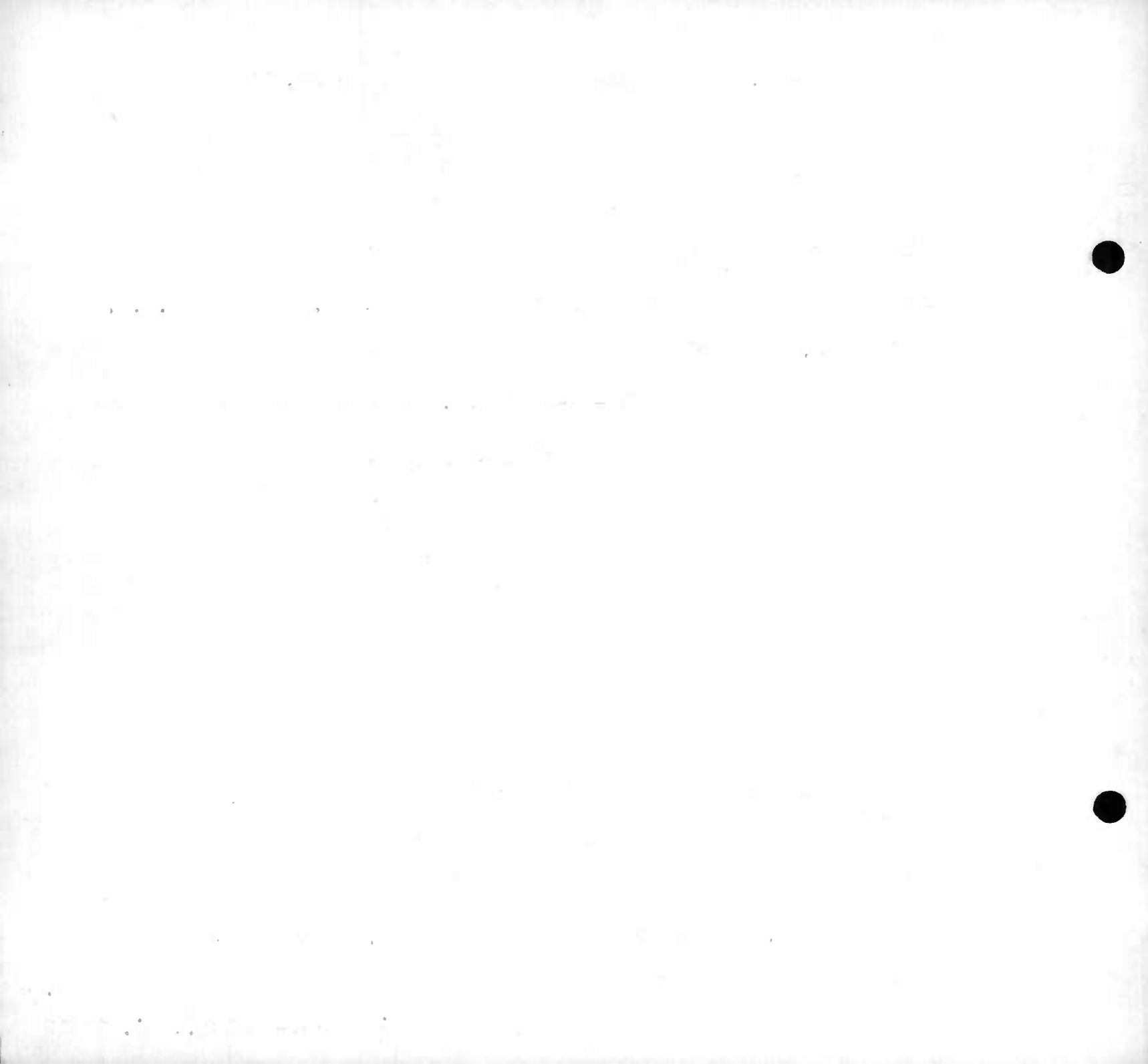




# FUNERAL DIRECTOR: IMPORTANT

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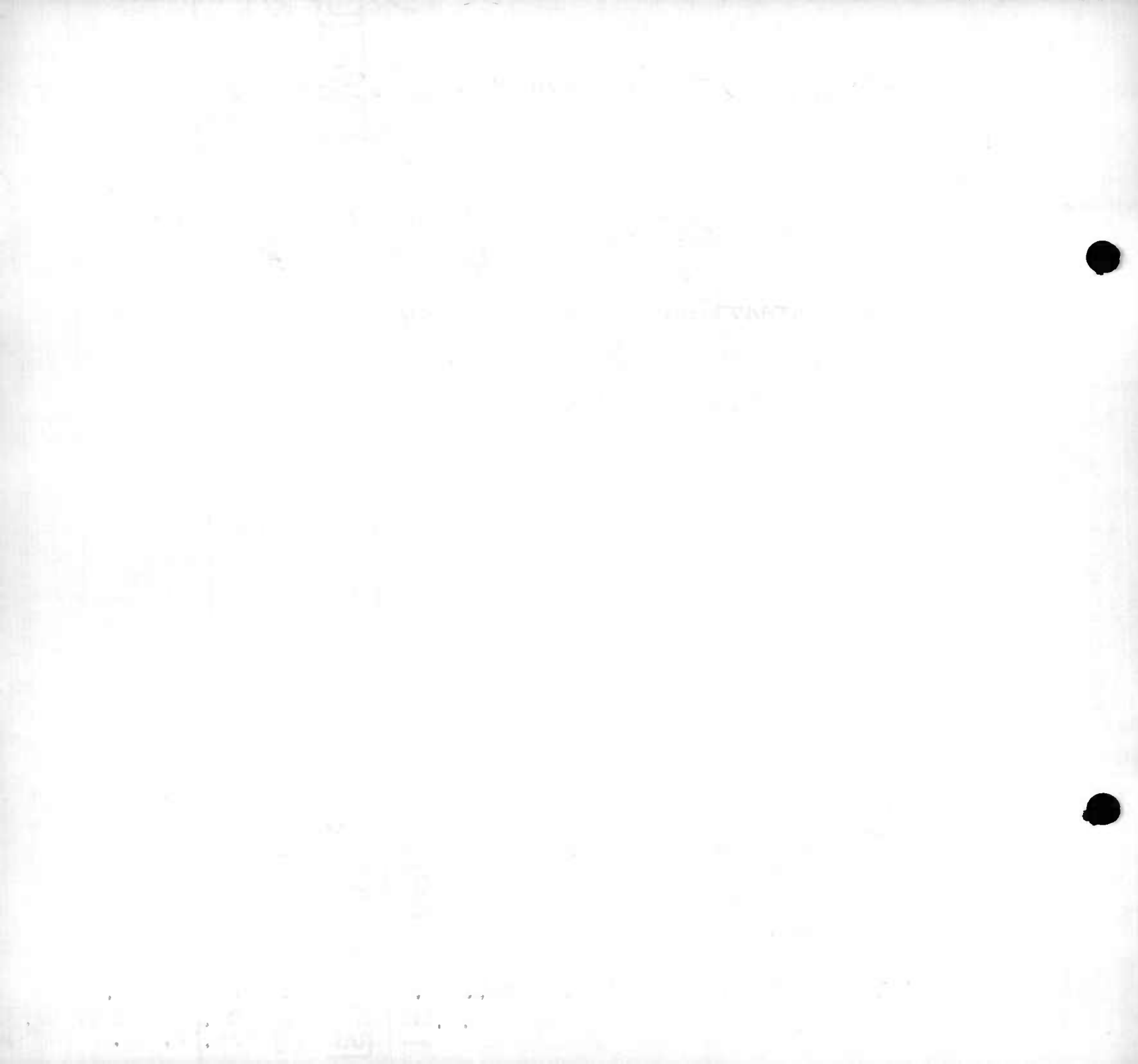
BIRTH NO. 67 6142				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6142	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				William E. Chamberlain		June 22, 1967 8:00 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Union Memorial Hospital				Baltimore		D. STREET ADDRESS (If rural, give location)	
1214 Ramblewood Road				5. SEX		6. RACE	
Male				White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
Married				8. DATE OF BIRTH		9. AGE (In years last birthday)	
8/14/1893				73		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Agent				Manufacturing		Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Benjamin J. Chamberlain				Mary Howard			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				212-09-1293		Mrs. Margaret Chamberlain (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO		1 hour +	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		10+ years	
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		10+ years	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1956 to June 22, 1967, that (I) last saw the deceased alive on June 22, 1967, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE		23B. DATE SIGNED	
Louis P. Hamburger				M.D. Attending Phys. Med. Director Staff Phys.		June 23, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)	
24B. DATE				24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
6/26/67				Woodlawn		Baltimore County Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 26 1967				Henry W. Jenkins & Sons Co.		4905 York Road - Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <u>192366</u>		6143		67 6143	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or print) <u>Gosnell, Wilfred Claude</u>		2. DATE AND HOUR OF DEATH <u>6-25-67</u> <u>710</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>USP.H.S. Hosp.</u>		A. STATE <u>Md.</u> B. COUNTY <u>Balto</u> C. CITY OR TOWN <u>Balto</u> D. STREET ADDRESS (If rural, give location) <u>3621 Kimble Rd.</u>			
(If not in hospital or institution, give street address or location)					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>May 22, 1902</u>	9. AGE (In years lost birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Consultant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Good Humor</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>Wilfred C. Gosnell</u>		14. MOTHER'S MAIDEN NAME <u>Addie E. Green</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>215056196</u>		17. INFORMANT <u>MRS. GRACE GOSNELL (same)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>cardiac arrest</u> DUE TO <u>myocardial infarction</u>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-25</u> 19 <u>67</u> to <u>6-25</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-25</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edward Y. Schulman, M.D.</u>				23B. DATE SIGNED <u>6-25-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Edward Y. Schulman</u>				23D. ADDRESS <u>500 W University Ave</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/28/1967</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat. Cem.</u>	
24D. LOCATION <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 26 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>			



BIRTH NO. 67  
M.E. CASE NO.6144

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 61441. NAME OF DECEASED  
(Type or Print)

NELLIE

NESBIT

2. DATE AND HOUR PRONOUNCED DEAD

June 25, 1967

12:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

4014 Maine Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4014 Maine Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug 22 - 1910

9. AGE (In years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Spartanburg, S.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Cheeks

14. MOTHER'S MAIDEN NAME

Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Kloane Nesbit 4014 Maine Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/25/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/29/67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 27 1967

24B. NAME OF REGISTRAR

R. B. E. Feltman

24C. FUNERAL DIRECTOR

Clifton L. Hanson 2427 W. North Ave.

ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 6145	
BIRTH NO. 67 6145		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>OCTAVIO F. RUIZ</b>		2. DATE AND HOUR OF DEATH <b>6-19-1967 11:15 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS Hosp.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21207 5300</b>			
		D. STREET ADDRESS (If rural, give location) <b>7402 SHIRLEY ROAD</b>			
5. SEX <b>M</b>	6. RACE <b>Cauc.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7-7-89</b>	9. AGE (In years lost birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUBA</b>	12. CITIZEN OF WHAT COUNTRY? <b>CUBA</b>
13. FATHER'S NAME <b>ALFREDO RUIZ</b>			14. MOTHER'S MAIDEN NAME <b>CORRALES</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NA</b>	17. INFORMANT ADDRESS <b>OCTAVIO RUIZ, JR. 7402 SHIRLEY RD. #7</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>UREMIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ACUTE RENAL FAILURE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>			
		INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>FRACTURE OF RT. HIP</b>					
19A. DATE OF OPERATION <b>6-16-1967</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RT SIDED HIP FRACTURE</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOME</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>7402 Shirley Rd BALT 21207</b>	
21D. TIME OF INJURY (APPROX.) <b>6-11-67 8:30 AM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell from his feet</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>6-11-67</b> to <b>6-19-1967</b> , that (I) (we) last saw the deceased alive on <b>6-19-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Agustini del Campo</b> M.D.				23B. DATE SIGNED <b>6-19-67-1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>AGUSTIN del CAMPO</b>				23D. ADDRESS <b>Bon Secours Hosp. BALTIMORE Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 22, 1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>Ridge Cemetery Pikesville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Frank H. Tenell, Pikesville, Md.</b>	





FUNERAL DIRECTOR: IMPORTANT

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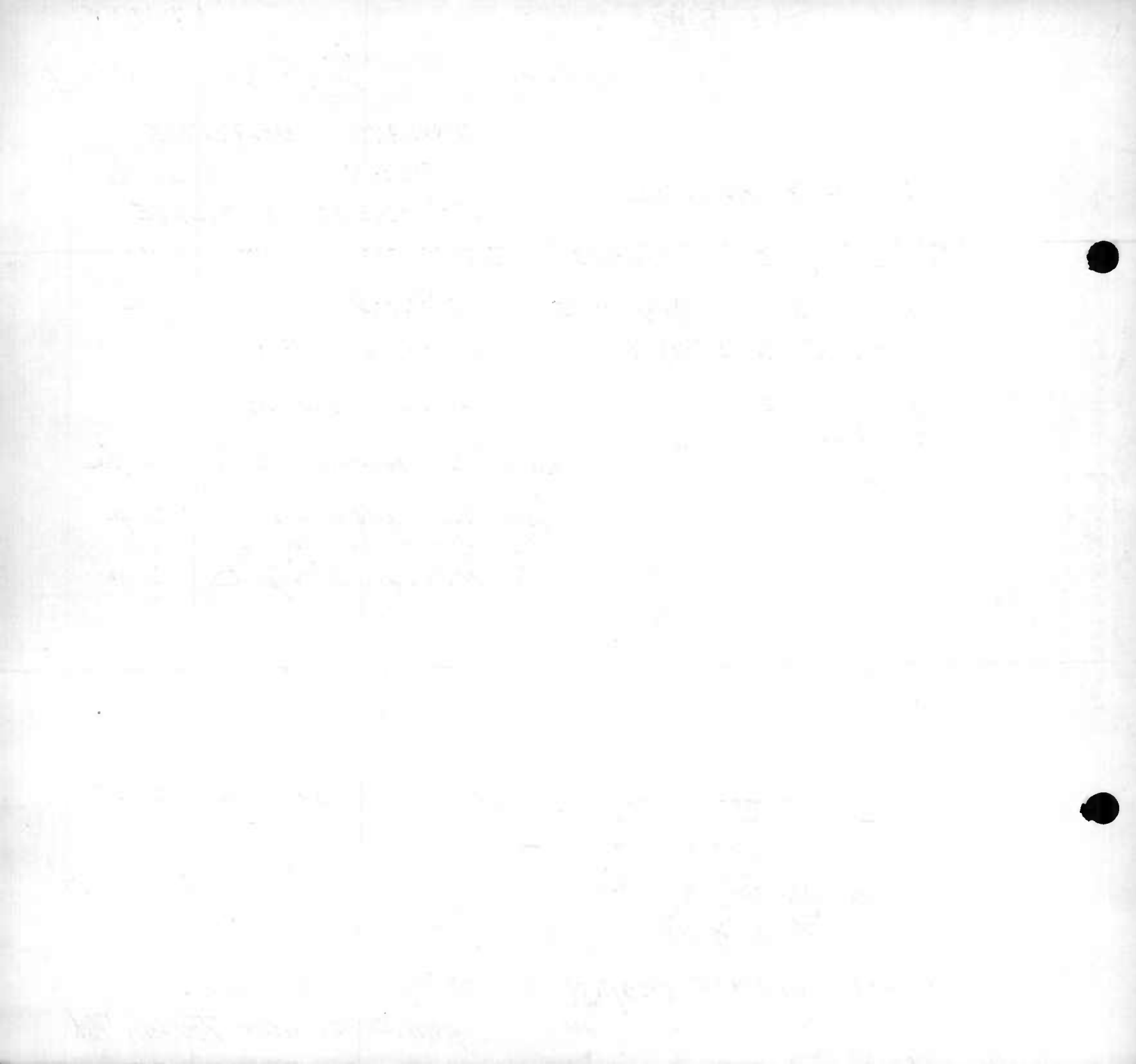
BIRTH NO. <b>67 6146</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 6146</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>EDITH SOLLERS</b>		2. DATE AND HOUR OF DEATH <b>6/17-67</b> <b>8:1 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Balto</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Pikesville, Md. 53-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Bolton Hill Nursing</b>		D. STREET ADDRESS (If rural, give location) <b>2608 Windsor Road</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>(WIDOWED)</b> DIVORCED (specify)	8. DATE OF BIRTH <b>4-1-1895</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll Co. Md.</b>	
13. FATHER'S NAME <b>Whitfield F. Sullivan</b>		14. MOTHER'S MAIDEN NAME <b>Katie M. Frock</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-10-8190</b>		17. INFORMANT <b>Mr. Raymond F. Sullivan</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>260X I</b>		CAUSE OF DEATH (A) DUE TO <b>Congestive Heart Failure</b> years		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>None</b>		(B) DUE TO <b>arteriosclerotic cardiovascular</b> years			
		(C) <b>Diabetic mellitus</b> years			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/12</b> 19 <b>67</b> to <b>June 17</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>June 17</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>allan h. macht</b> M.D.				23B. DATE SIGNED <b>6/17/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALLAN H. MACHT</b> M.D.				23D. ADDRESS <b>2 E. READ ST. 21202</b>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<b>Burial</b>		<b>June 20, 1967</b>		<b>Union Field Cemetery, Pikesville 8, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>JUN 27 1967</b>		<b>Robert E. Taylor</b>		<b>Newell Funeral Home Pikesville 8, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

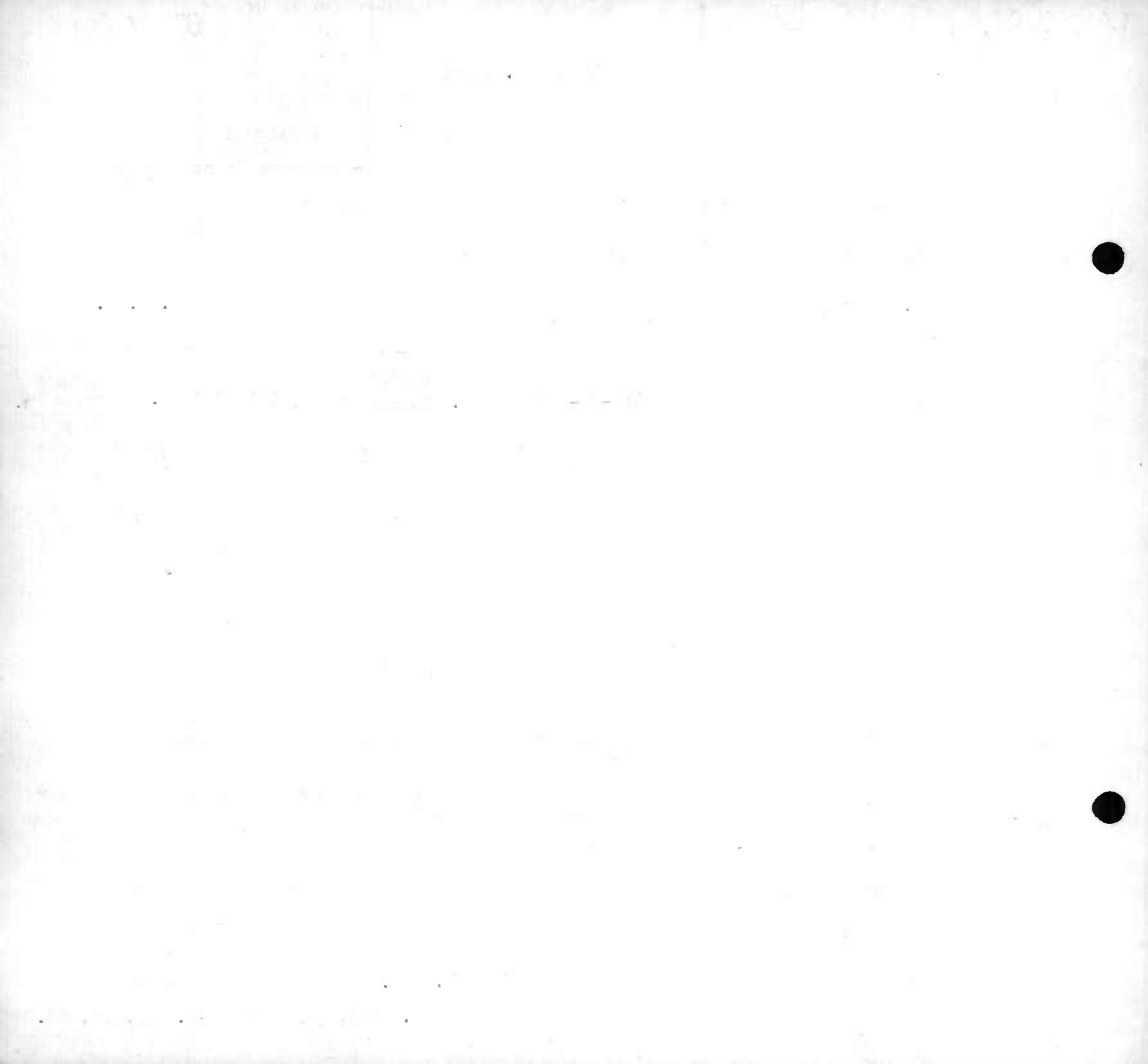
67 6147		BALTIMORE CITY HEALTH DEPARTMENT		67 6147	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>		Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>SAMANA PARKER</i>		2. DATE AND HOUR OF DEATH <i>6-22-67 3:33 A.M.</i>	
1. NAME OF DECEASED (Type or Print)					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIVERSITY HOSPITAL</i>		A. STATE <i>MARYLAND</i>		B. COUNTY <i>BALTIMORE</i>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>TOWSON</i>			
		D. STREET ADDRESS (If rural, give location) <i>35 ALLEGHANY AVENUE</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>OCT. 28, 1889</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
13. FATHER'S NAME <i>CLAUDIUS R. LUMPKIN</i>		14. MOTHER'S MAIDEN NAME <i>LAURA M. LUMPKIN</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS <i>FAMILY RECORDS</i>	
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Dissecting Aneurysm of Aorta</i> DUE TO (B) <i>Hypertensive Interstitial Cardiovascular Disease</i> DUE TO (C) <i>Old Myocardial Infarct</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i> <i>5 yrs</i> <i>2 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>May 1958</i> to <i>6-22-67</i> 19 <i>67</i> that (I) ( <del>we</del> ) last saw the deceased alive on <i>6-22-67</i> 19 <i>67</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (4) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Kyle G. Swisher Jr</i> M.D.				23B. DATE SIGNED <i>6-22-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Kyle G. Swisher Jr</i> M.D.		23D. ADDRESS <i>Univ. Hosp. - Balt, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>June 24, 1967</i>	24C. NAME of CEMETERY or CREMATORY <i>Prospect Hill Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Towson, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 27 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John Burns' Sons, Towson, Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

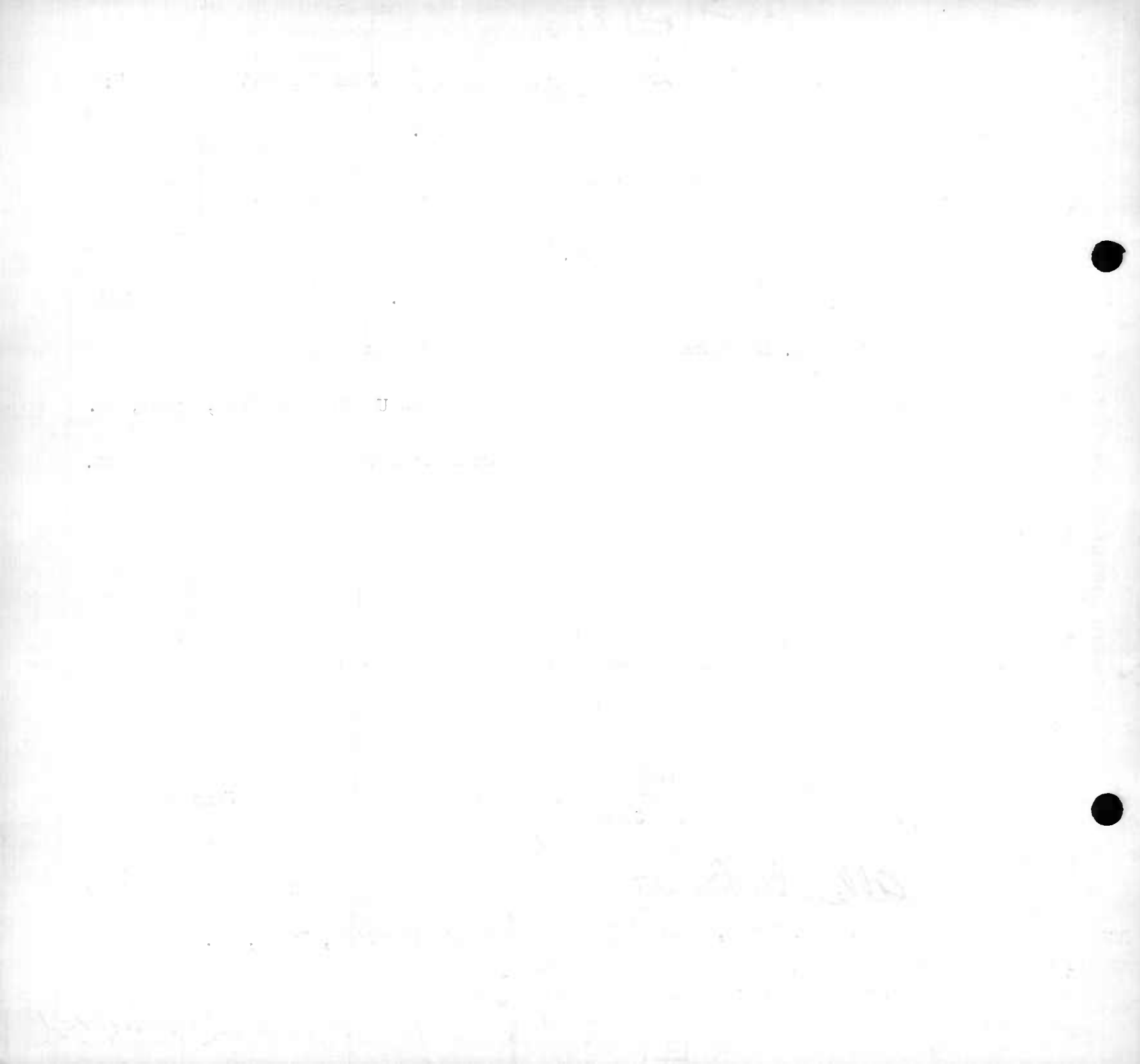
BIRTH NO. <span style="font-size: 2em;">67 6148</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 2em;">67 6148</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>William Vadas</i>		2. DATE AND HOUR OF DEATH <i>6-25-67 1:55 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto. - Sparrows Point 53-00</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home &amp; Hosp.</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>1116 H St.</i>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <i>6/21/1902</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gen. Foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED BETH STEEL CO.</b>		11. BIRTHPLACE (State or foreign country) <b>HUNGARY</b>	
13. FATHER'S NAME <b>JAMES VADAS</b>		14. MOTHER'S MAIDEN NAME <b>MARY ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-0039</b>		17. INFORMANT (Wife) <b>Mrs. Matilda Vadas, 1116 "H" St. Sparrows Pt. Maryland</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>581.01 Pulmonary Edema</b>		CAUSE OF DEATH (A) DUE TO <b>Pulmonary Edema</b> (B) DUE TO <b>Postural Cirrhosis</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Few hours</b> <b>Several yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>6-25-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-23 1967</i> to <i>6-25 1967</i> , that (I) (we) last saw the deceased alive on <i>6-25 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rodolfo M. Liri</i> M.D.				23B. DATE SIGNED <i>6-25-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Rodolfo M. Liri</i>		23D. ADDRESS <i>Church Home &amp; Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <i>6/29/67</i>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Memorial Pk. Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>			
25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6149	
BIRTH NO. 67 6149		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Amelia <del>Brazinski</del> BRZENLENSKI</u>		2. DATE AND HOUR OF DEATH <u>June 22, 1967</u> <u>7:10 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>US Public Health Service Hospital</u> <u>3100 Wyman Park Drive</u>		A. STATE <u>Md.</u> B. COUNTY <u>27-03</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		D. STREET ADDRESS (If rural, give location) <u>4908 1/2 Harford Road</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Wid.</u>	8. DATE OF BIRTH <u>12/21/79</u>	9. AGE (In years lost birthday) <u>87</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Robert E. Handloser</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Mann</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Records- US PHS Hospital, Balto, Md.</u>	
18. <u>199-2-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinomatosis</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>May 8</u> 19 <u>67</u> to <u>June 22</u> 19 <u>67</u> , that (1) (we) lost saw the deceased alive on <u>June 22</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Allen B. Bredt</u>				23B. DATE SIGNED <u>6/22/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Allen B. Bredt, Surg (R)</u>				23D. ADDRESS <u>US PHS Hospital, Balto, Md.</u>	
24A. MORTAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/21/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 27 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MA</u>		25C. FUNERAL DIRECTOR <u>W. Heermann</u>	
25D. ADDRESS <u>6067 Hay Rd</u>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6150		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6150	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WADE, LOUISE NMN		2. DATE AND HOUR OF DEATH 6/25/1967 6 <sup>20</sup> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY Balto			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Arm 21037 53-00			
		D. STREET ADDRESS (If rural, give location) Rt 1 Box 639-75			
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		B. DATE OF BIRTH 07-15-1978	9. AGE (In years lost birthday) 88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME August Lowensen		14. MOTHER'S MAIDEN NAME Elizabeth Seibert	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs Clarence F Miller daughter from chart	
18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Arteriosclerotic heart disease DUE TO (B) Pneumonia L. lower lobe DUE TO (C) Pulmonary Infarction (?) Dr. Krause her private doctor notified.		INTERVAL BETWEEN ONSET AND DEATH 13 days.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from Jun 12 1967 to Jun 25 1967, that (we) doctors last saw the deceased alive on Jun 24 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (view) the body after death.					
23A. SIGNATURE Giselle Bretz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Jun 25, 1967	
23C. PHYSICIAN'S NAME (Type) DR GISSIE BRETZ Giselle Bretz		23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/67		24C. NAME OF CEMETERY or CREMATORY Parkwood Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore Co.		25A. DATE REC'D BY HEALTH DEPT. JUN 27 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Lassahn Funeral Home 2401 Belvoir			

Box 100-12

07-12-1918 38

U.S. 2-11

Elizabeth J. J. J.

Mar. Lawrence F. Miller

Elizabeth J. J. J.

Elizabeth J. J. J.

Elizabeth J. J. J.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 67 12177					67 6151					
M.E. CASE NO.					CERTIFICATE OF DEATH					
1. NAME OF DECEASED					2. DATE AND HOUR OF DEATH					
Baky Giel Solomon					6/21/67 - 4:56 P					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY					
The Johns Hopkins Hospital					MARYLAND, BALTIMORE					
BALTIMORE Md. 21205					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
					D. STREET ADDRESS (If rural, give location)					
					2514 Cylburn Ave					
5. SEX		6. RACE		7. MARRIED (If married, give date of marriage) (If widowed, give date of widowhood)		8. DATE OF BIRTH		9. AGE (In years, months, days)		
F		N		MARRIED		6/20/67		24 2		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
N/A			N/A			MARYLAND			USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Lonnie B. Solomon					Mary B. Newsome					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No					N/A					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO					
ANTECEDENT CAUSES					CARDIAC ARREST 5 minutes					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO					
					Respiratory Arrest 3 hrs					
					possible Congenital Heart Disease -					
19. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
None					None					
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
Yes					No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
No										
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED					
N/A					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from					22. I certify that (I) (this hospital) attended the deceased from					
6/20 1967 to 6/21 1967					6/20 1967 to 6/21 1967					
that (I) (we) lost saw the deceased alive on					that (I) (we) lost saw the deceased alive on					
6/21 1967					6/21 1967					
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE					23B. DATE SIGNED					
James B. Brayton					6/21/67					
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
James B. Brayton					The Johns Hopkins Hosp. Balt. Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
CREMATION			6-22-67		JOHNS HOPKINS HOSPITAL			BALTIMORE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS	
JUN 27 1967			Robert E. Taylor							

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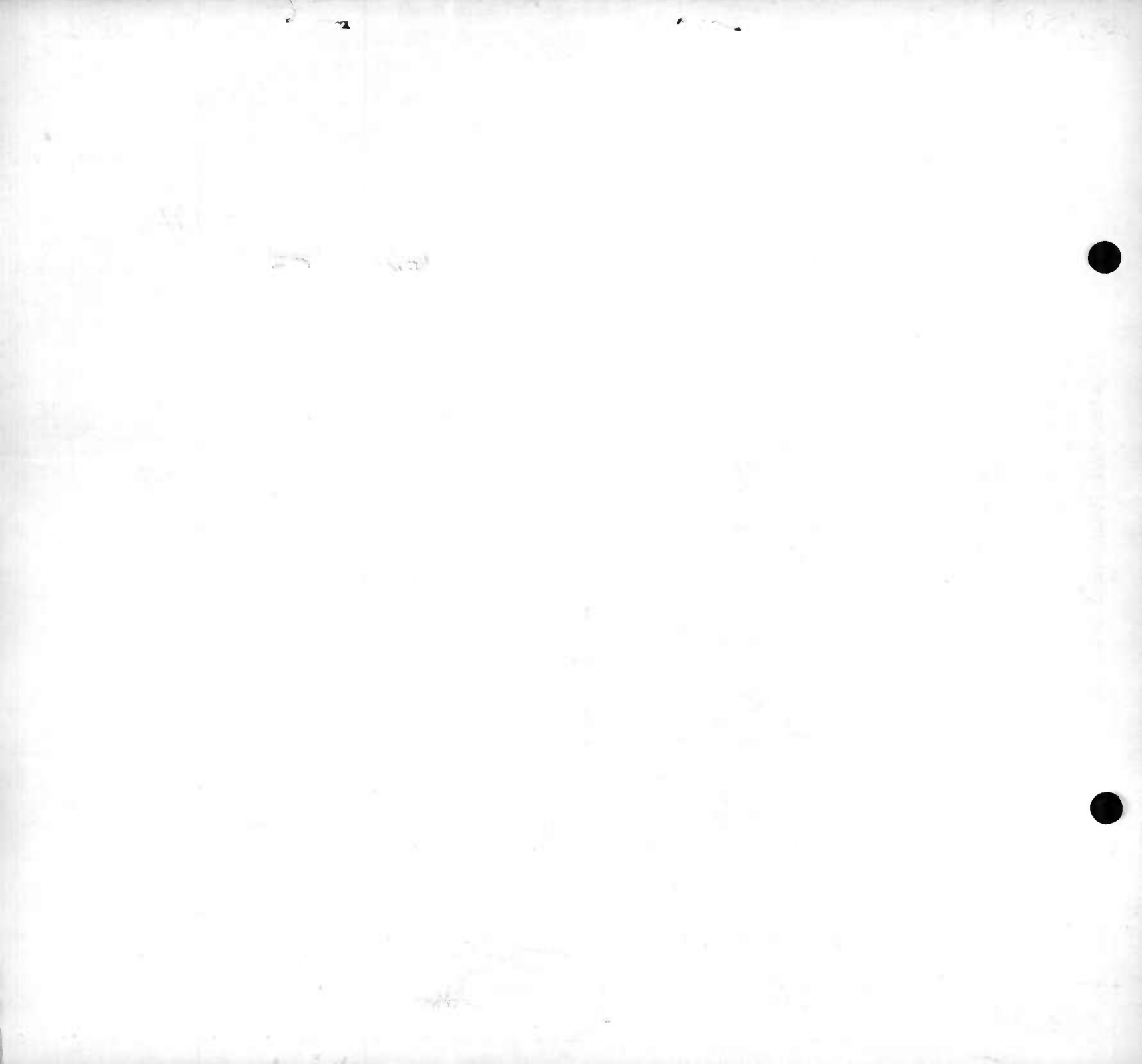
7/5/0

James B. Braxton  
James B. Braxton

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

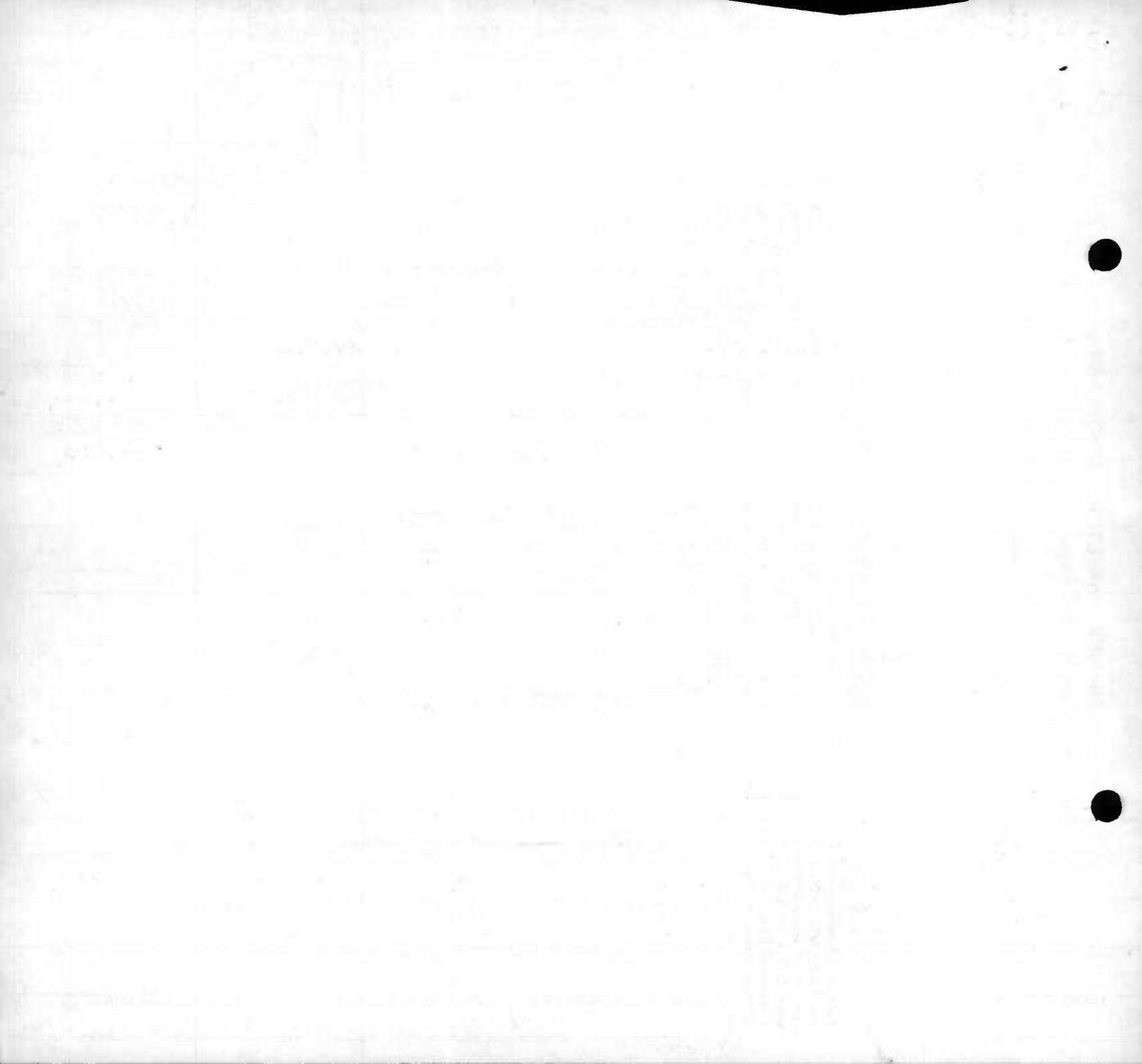
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 6152	
BIRTH NO. 67 6152		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BELLE LEVIN</b>						2. DATE AND HOUR OF DEATH <b>6/23/67</b>		46 <b>6 P</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL OF BALTIMORE</b>						A. STATE <b>MARYLAND</b>					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>					
						D. STREET ADDRESS (If rural, give location) <b>3922 W. GARRISON AVE</b>					
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>W</b>		8. DATE OF BIRTH <b>3/14/1893</b>		9. AGE (In years lost birth day) <b>74</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>				11. BIRTHPLACE (State or foreign country) <b>LATVIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BARNEY KOPKINS</b>						14. MOTHER'S MAIDEN NAME <b>MOLLIE ?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>MRS. MINNIE KAHN, 6402 PARK HEIGHTS AVENUE</b>					
18. <b>4201 I</b>						CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						(A) <b>ACUTE MYO CARDIAL INFARCTION</b>					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)						(B) DUE TO					
ANTECEDENT CAUSES						(C) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>6/23/67</b> to <b>6/23/67</b> , that <del>he</del> (we) lost saw the deceased alive on <b>6/23/67</b> and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (We) (did) (didn't) view the body after death.											
23A. SIGNATURE <b>J. Brett Lazar</b> M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>6/23/67</b>		
23C. PHYSICIAN'S NAME (Type) <b>J. BRETT LAZAR</b>						23D. ADDRESS <b>Sinai Hospital</b> M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/25/67</b>		24C. NAME of CEMETERY or CREMATORY <b>BETH YEHUDA ANSHE KURLAND</b>				24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>				25B. NAME OF REGISTRAR <b>DR. E. J. Taylor</b>				25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.5em;">67 6153</span>	
BIRTH NO. <span style="font-size: 1.5em;">67 6153</span>		<b>CERTIFICATE OF DEATH</b>		DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">June 22/67 10 P. M.</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">Morris Stark</span>		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE <span style="font-size: 1.5em;">Maryland</span>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
<span style="font-size: 1.5em;">4613 Park Heights Ave Mt Sinai Nursing Home</span>		<span style="font-size: 1.5em;">Baltimore</span>		<span style="font-size: 1.5em;">3310 Spaulding Ave</span>	
5. SEX <span style="font-size: 1.5em;">Male</span>	6. RACE <span style="font-size: 1.5em;">White</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.5em;">Widower</span>	8. DATE OF BIRTH <span style="font-size: 1.5em;">July 15, 1882</span>	9. AGE (In years last birthday) <span style="font-size: 1.5em;">84</span>	Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<span style="font-size: 1.5em;">Retired Tailor</span>		<span style="font-size: 1.5em;">Shap (Lebanon)</span>		<span style="font-size: 1.5em;">Austria</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.5em;">Unknown</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Unknown</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">Unknown</span>		17. INFORMANT <span style="font-size: 1.5em;">Moscov Goldstein</span> ADDRESS <span style="font-size: 1.5em;">apt 101 6318 Greenspring Ave</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<span style="font-size: 1.5em;">260X I</span>		<span style="font-size: 1.5em;">Arteriosclerotic Heart Disease</span>		<span style="font-size: 1.5em;">6 years</span>	
ANTECEDENT CAUSES		(A) DUE TO <span style="font-size: 1.5em;">Diabetes Mellitus</span>		<span style="font-size: 1.5em;">6 years</span>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C)			
II		<span style="font-size: 1.5em;">None</span>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.5em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.5em;">July 15, 1961</span> to <span style="font-size: 1.5em;">June 22, 1967</span> , that (I) ( <del>was</del> ) last saw the deceased alive on <span style="font-size: 1.5em;">June 22, 1967</span> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Mannal Levin</span>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.5em;">6/23/67</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">MANNAL LEVIN</span>		23D. ADDRESS <span style="font-size: 1.5em;">4818 REISTERSTOWN ROAD</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>		24B. DATE <span style="font-size: 1.5em;">June 23/67</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.5em;">Petach Tikvah</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Rosedale, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">JUN 27 1967</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Jackson</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Sol Leinson</span>		25D. ADDRESS <span style="font-size: 1.5em">-6010 Reest. Road</span>			

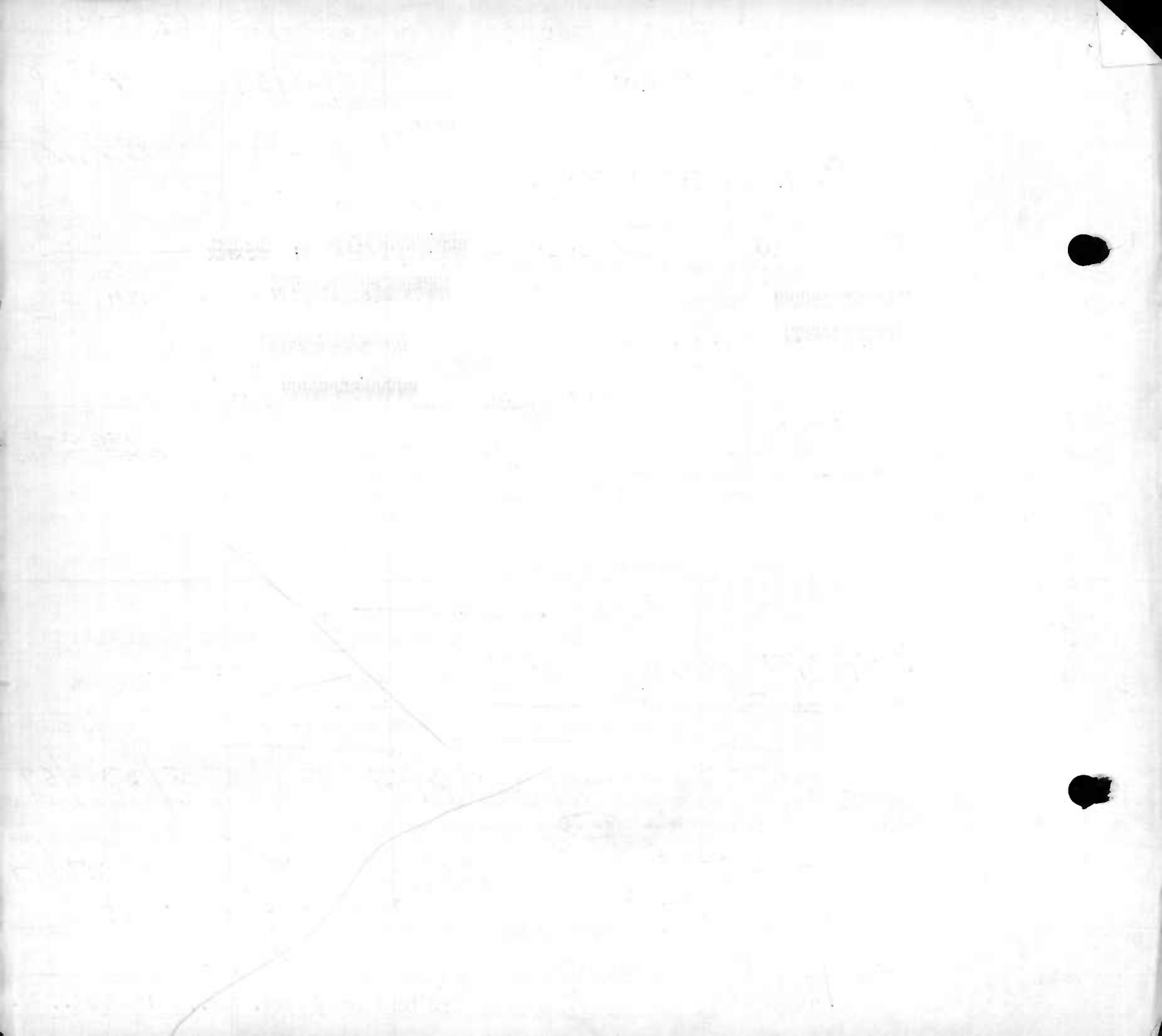




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6154	
BIRTH NO. 67 6154		CERTIFICATE OF DEATH		Registered No. 67 6154	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BERTHA KORN		2. DATE AND HOUR OF DEATH 5/23/67 4:48 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-18	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL		D. STREET ADDRESS (If rural, give location) 5311 NELSON AVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED 4-15-1886	8. DATE OF BIRTH	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LATVIA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME BERS, HERSCHEL		14. MOTHER'S MAIDEN NAME HANNAH		ADDRESS ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MR. HOWARD RUBIN, 5411 Gist Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO DIVERTICULOSIS & LOWER GI BLEEDING (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH WEEKS - MONTHS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/20/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LOWER GI BLEEDING		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/18/67 to 5/23/67 that (I) (we) lost saw the deceased alive on 5/23/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F H Cort		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/23/67	
23C. PHYSICIAN'S NAME (Type) F H Cort		M.D. 23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/25/67		24C. NAME OF CEMETERY or CREMATORY Bnai Israel	
24D. LOCATION Baltimore, Maryland		24E. STATE			
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6155		CERTIFICATE OF DEATH		Registered No. 67 6155	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>KLOTZMAN, Hortense</b>			6-22-67 10:10 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <b>THE JOHNS HOPKINS HOSPITAL</b>			A. STATE <b>MARYLAND</b>		
			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			<b>BALTIMORE</b>		
			D. STREET ADDRESS (If rural, give location)		
			<b>3604 CLARINTH ROAD</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>7-5-05</b>	9. AGE (In years lost birthday) <b>61</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>SIGMUND OCHS</b>			14. MOTHER'S MAIDEN NAME <b>HELEN WICKENSTEIN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-26-1316</b>	17. INFORMANT ADDRESS <b>MR. DAVID M. BRENNER, 111 NORTH CHARLES ST.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>CARCINOMA EN'CEPHALIS 2YRS</b>  <b>CARCINOMA OF BREAST</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>MAY 1965</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF BREAST</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <u>this hospital</u> attended the deceased from <u>6-13-67</u> 19 to <u>6-22</u> 19 <u>67</u> , that (1) <u>(we)</u> last saw the deceased alive on <u>6-22</u> 19 <u>67</u> and that in (my) <u>(aur)</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <b>James L. Phillips</b>			23B. DATE SIGNED <b>6-22-67</b>		
23C. PHYSICIAN'S NAME (Type) <b>JAMES L. PHILLIPS</b>			23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/25/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>HEBREW FRIENDSHIP</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Anderson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>			

K202-404, 402-404

6-23-67 1044 A

CARCINOMA OF BREAST  
CARCINOMA OF BREAST

MAY 1967 CARCINOMA OF BREAST

6-23-67

6-23-67

○

○

○

James J. [Signature]

X

6-23-67

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED

(Type or Print)

MEYER

RALPH

CAPLAN

2. DATE AND HOUR PRONOUNCED DEAD

June 23, 1967

2:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Albion Hotel  
900 Cathedral Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

900 Cathedral Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

April 10, 1918

9. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

automobiles

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Victor Caplan

14. MOTHER'S MAIDEN NAME

Mary Potts/

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Jack Caplan- 2905 Taney Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/24/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

June 25/67

23C. NAME of CEMETERY or CREMATORY

Beth Ham. Bagodol

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 27 1967

24B. NAME OF REGISTRAR

Robert E. Faltys

24C. FUNERAL DIRECTOR

Sol. Levinson &amp; Bros. Inc. 6010 Reistestown Rd.

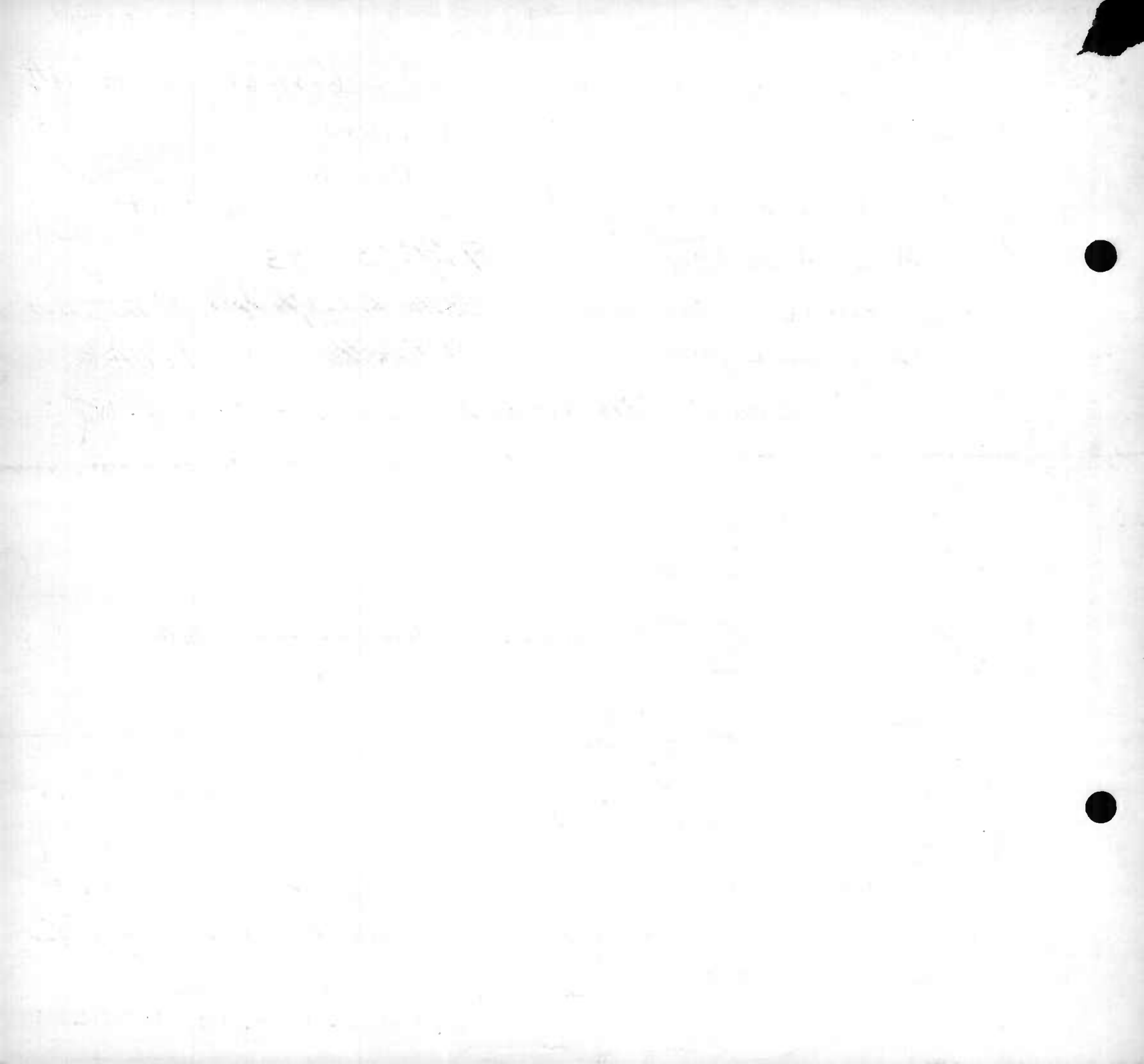
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 6157		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 67 6157	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Simon Snyder</b>			2. DATE AND HOUR OF DEATH <b>6-24-67 10:14 AM</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Church Home &amp; Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>3-01</b> D. STREET ADDRESS (If rural, give location) <b>288 South Dallas Court</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>9/14/893</b>	9. AGE (In years last birthday) <b>73</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Junk Dealer</b>		
11. BIRTHPLACE (State or foreign country) <del>Russian</del> <b>Russian</b>			12. CITIZEN OF WHAT COUNTRY? <b>American</b>		
13. FATHER'S NAME <b>Benjamin SNYDER</b>			14. MOTHER'S MAIDEN NAME <del>KAPLAN</del> <b>KAPLAN, DENA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unk known</b>			16. SOCIAL SECURITY NO. <b>548-24-3673</b>		
17. INFORMANT <b>Nathan Snyder-4141 Park Hts. Avenue</b>			18. CAUSE OF DEATH <b>Arteriosclerosis Heart Disease ? years</b>		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerosis Heart Disease ? years</b>			20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Central Arteriosclerosis; Diabetes</b>		
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-24</b> 19 <b>67</b> to <b>6-24</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-24</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Roderio M. Lim</b> M.D.				23B. DATE SIGNED <b>6-24-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Roderio M. Lim</b> M.D.				23D. ADDRESS <b>Church Home &amp; Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 25/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Hebrew Young Men</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sol. Levinson- &amp; Bros. Inc 6010 Reist. Rd</b>			





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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6158</b>	
BIRTH NO. <b>67 6158</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Fink, William B.</b>		2. DATE AND HOUR OF DEATH <b>6/22/67 9:00 PM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2906 Sulgrave Avenue</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>3/15/04</b>	9. AGE (In years lost birthday) <b>63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AGENT-RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
13. FATHER'S NAME <b>BAROUCH FINKELSTEIN</b>		14. MOTHER'S MAIDEN NAME <b>ANVA ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-03-8672</b>		17. INFORMANT <b>MRS. IRENE FINK, 2906 SULGRAVE AVENUE</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CVA</b> <b>ASAD</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>10 YRS</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6/20/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/12/67</b> to <b>6/22/67</b> , that (I) (we) last saw the deceased alive on <b>6/22/67</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>David Spott</b>				23B. DATE SIGNED <b>6/22/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>D.A. SPOTT M.D.</b>				23D. ADDRESS <b>Sinai Hosp of Balt</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/25/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH EL</b>	
24D. LOCATION (City, town, or county) (State) <b>RANDALLSTOWN, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>			
25B. NAME OF REGISTRAR <b>Charles E. Taylor, MA</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>			

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Handwritten text in the lower section, including some legible words like "ST" and "SP/11/12".

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Dr. Fisher said via telephone - Not A M. E. Cause  
2511  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

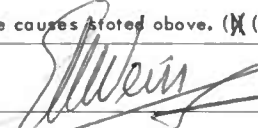
FUNERAL DIRECTOR: IMPORTANT

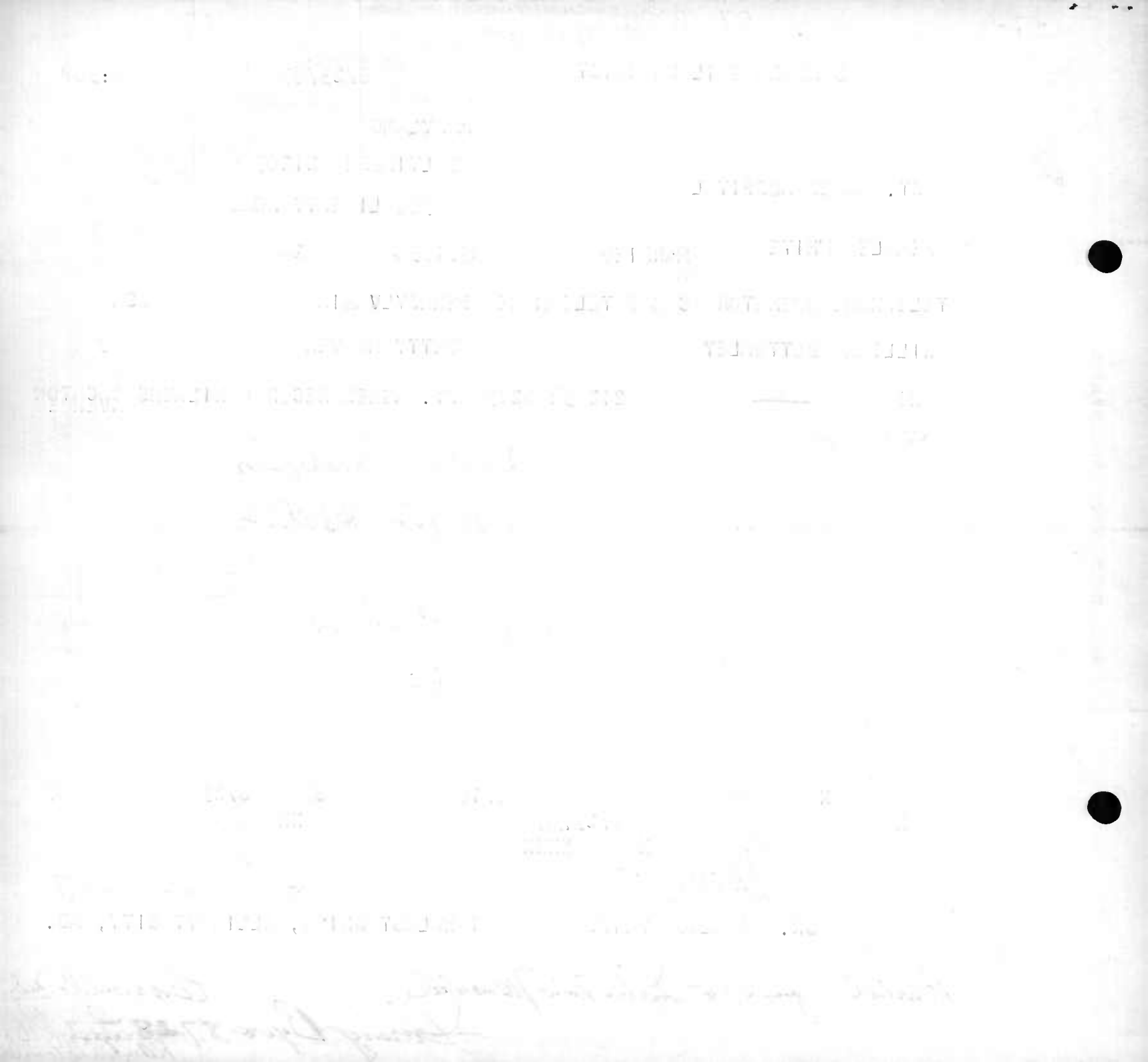
BIRTH NO. 67 6159		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6159	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		Grace S. Rosenberg		6/26/67 7 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)		Md.			
610 Washington Blvd.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		22-02	
		D. STREET ADDRESS (If rural, give location)		610 Washington Blvd.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE in years (last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	white	married	4/26/17	50	Attendant
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Attendant		Laundry Co.		Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles J. Eitel		Lula Bertholdt		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		-?		Mr Philip Rosenberg	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		1. Advanced metastatic carcinoma of entire skeletal system with healing pathological fracture of the right femur.		since 1964	
2. Malignancy of left breast, 1964-3-Cachexia and secondary anemia.				since 1964	
3 months +-					
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from January 22 1964 to present time. 19 that (I) (we) last saw the deceased alive on June 2, 1967 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
R.V. Rangle, M.D.		6/26/67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
R.V. Rangle, M.D.		2938 St. Paul Street, Baltimore, Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6/27/67		Green Haven Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 27 1967		Robert E. Fisher		John J. Cowan	
				23. Md.	



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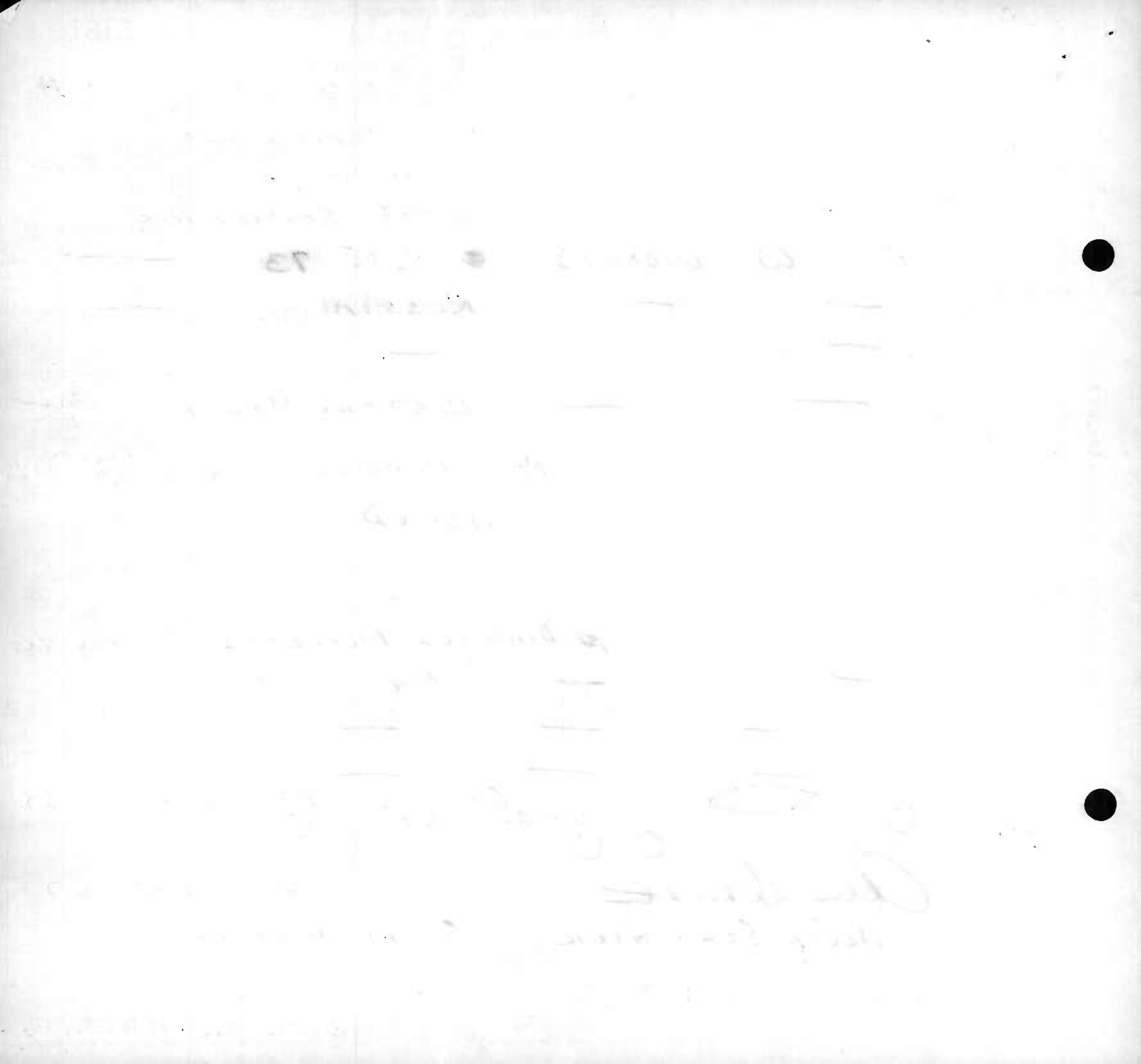
BIRTH NO. 67 6160		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6160	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>BARBARA GAIL BENEDICT</b>			2. DATE AND HOUR OF DEATH <b>6/23/67 8:30P M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21207</b> D. STREET ADDRESS (If rural, give location) <b>7900 LIBERTY ROAD</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b> WIDOWER, DIVORCED (specify)	8. DATE OF BIRTH <b>05/1/38</b>	9. AGE (In years lost birthday) <b>29</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TELEPHONE OPERATOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P TELEPHONE</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>WILLIAM BOTTOMLEY</b>		
14. MOTHER'S MAIDEN NAME <b>BETTY HOOVER</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>212 34 0215</b>			17. INFORMANT ADDRESS <b>ST. AGNES RECORDS WILKENS &amp; CATON AVENUE</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bulbar Paralysis</b>			CAUSE OF DEATH (A) DUE TO <b>Porphyria Hepatica</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Pneumothorax</b>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/10 1967</b> to <b>6/23 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6/23/67</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. ( <input checked="" type="checkbox"/> (We) (did) <b>XXXX</b> view the body after death.					
23A. SIGNATURE  M.D. <b>DR. EWALDO WEISS</b>				23B. DATE SIGNED <b>6-23-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. EWALDO WEISS</b>				23D. ADDRESS M.D. <b>1 WALNUT DRIVE, ELLICOTT CITY, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 27/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Liberty Rd. Carroll Co. Md.</b>	
24D. LOCATION (City, town, or county) <b>Liberty Rd. Carroll Co. Md.</b>		24E. NAME of REGISTRAR <b>John E. Farley</b>		24F. FUNERAL DIRECTOR <b>Loring Byers</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <b>John E. Farley</b>		25C. FUNERAL DIRECTOR <b>Loring Byers</b>	



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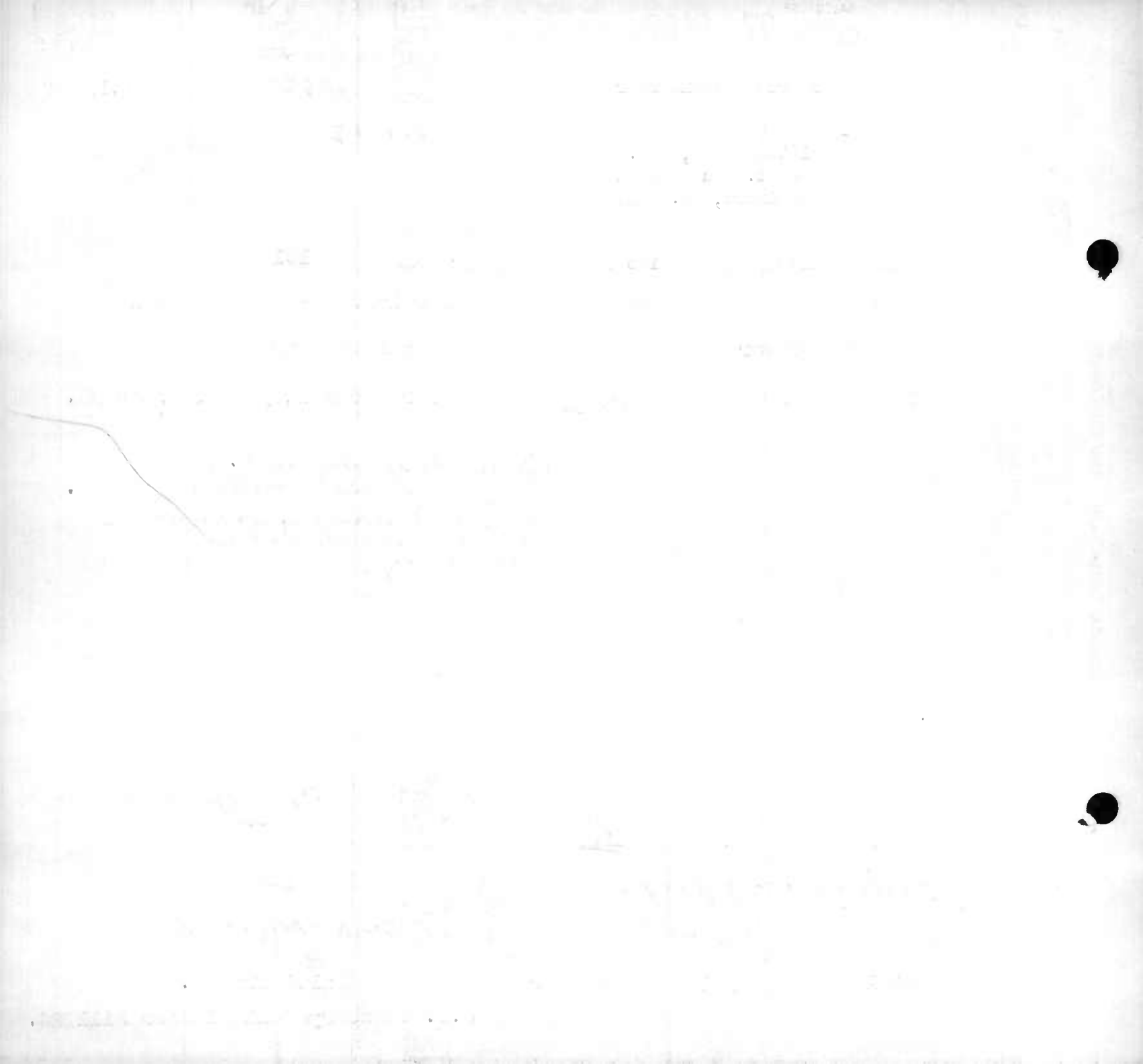
BIRTH NO. <b>67 6161</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 6161</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>MILLER, REBECCA</b>			2. DATE AND HOUR OF DEATH <b>6-21-67</b> <b>1</b> <b>A</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2449 SHIRLEY AVE.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>3-15-05</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>RUFKA BERKOWITZ</b>			14. MOTHER'S MAIDEN NAME <b>DEBORAH</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT <b>HOSPITAL CHART.</b>		
18. <b>422014260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION 20 DAYS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 DAYS</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>DIABETES MELLITUS SEVERAL YRS.</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <u>this hospital</u> attended the deceased from <b>6-1-67</b> to <b>6-21-67</b> , that (1) <u>we</u> last saw the deceased alive on <b>6-20-67</b> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above (1) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Alvin Schachter</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>6-21-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALVIN SCHACHTER</b> M.D.				23D. ADDRESS <b>SINAI HOSPITAL.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/22/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ANSIE EMMANUEL - Wash. Blvd. BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MA</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6162				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6162	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Margaret Katzenberger		6/25/67 2:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
Midtown Home, Inc. 808 St. Paul Street Baltimore, Md. 21202				Same # 3			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location)			
				808 St. Paul St.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Female		White		Widowed		1/28/1866	
						1/28/66	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
101		None		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Weaver				Salena Weigner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		214 56 4318		Henry Wehe		1403 Dorchester Rd. 21207	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) Cardio Respiratory Failure			
ANTECEDENT CAUSES				(B) Massive Increasing Infarction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Sclerotic			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Sept 25 1959 to June 25 1967, that (I) (we) last saw the deceased alive on June 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
William D. Appleford							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
William D. Appleford				5501 Park Heights Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/28/67		Loudon Park		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 27 1967		Robert E. Taylor		J.T. Stansbury		6411 Windsor Mill Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>Calvert 6. 7/67</u> 6163		BALTIMORE CITY HEALTH DEPARTMENT		67 6163	
FILE CASE NO.		REGISTERED NO.			
NAME OF DECEASED (Type or Print)		DATE AND HOUR OF DEATH			
TIMOTHY HURLEY		6-20-67		6:16 P M.	
PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL		MARYLAND, CALVERT			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		SUNDERLAND			
		D. STREET ADDRESS (If rural, give location)			
5. SEX MALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 4-5-65	9. AGE (In years last birthday) 2 YEARS	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME DANIEL HURLEY		14. MOTHER'S MAIDEN NAME STELLA TYLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Daniel Hurley Sunderland - Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease or injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. CAUSE OF DEATH Pseudomonas Septicemia 65% body burn 2+3°		INTERVAL BETWEEN ONSET AND DEATH 5 days 12 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Sunderland, Md 54-00	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) June 7-8 1967 (1)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell into tub of hot water	
22. I certify that (I) (this hospital) attended the deceased from June 16 19 67 to June 20 19 67. that (I) (we) last saw the deceased alive on June 20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herbert Swick MD		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 20 1967	
23C. PHYSICIAN'S NAME (Type) HERBERT SWICK		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) 6-23-67		24B. DATE 6-23-67		24C. NAME OF CEMETERY or CREMATORY St. Edmond Ch. Cem	
				24D. LOCATION (City, town, or county) (State) Sunderland Calvert Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1967		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR ADDRESS Pinkney & Sewell - Prince Georges, Md	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

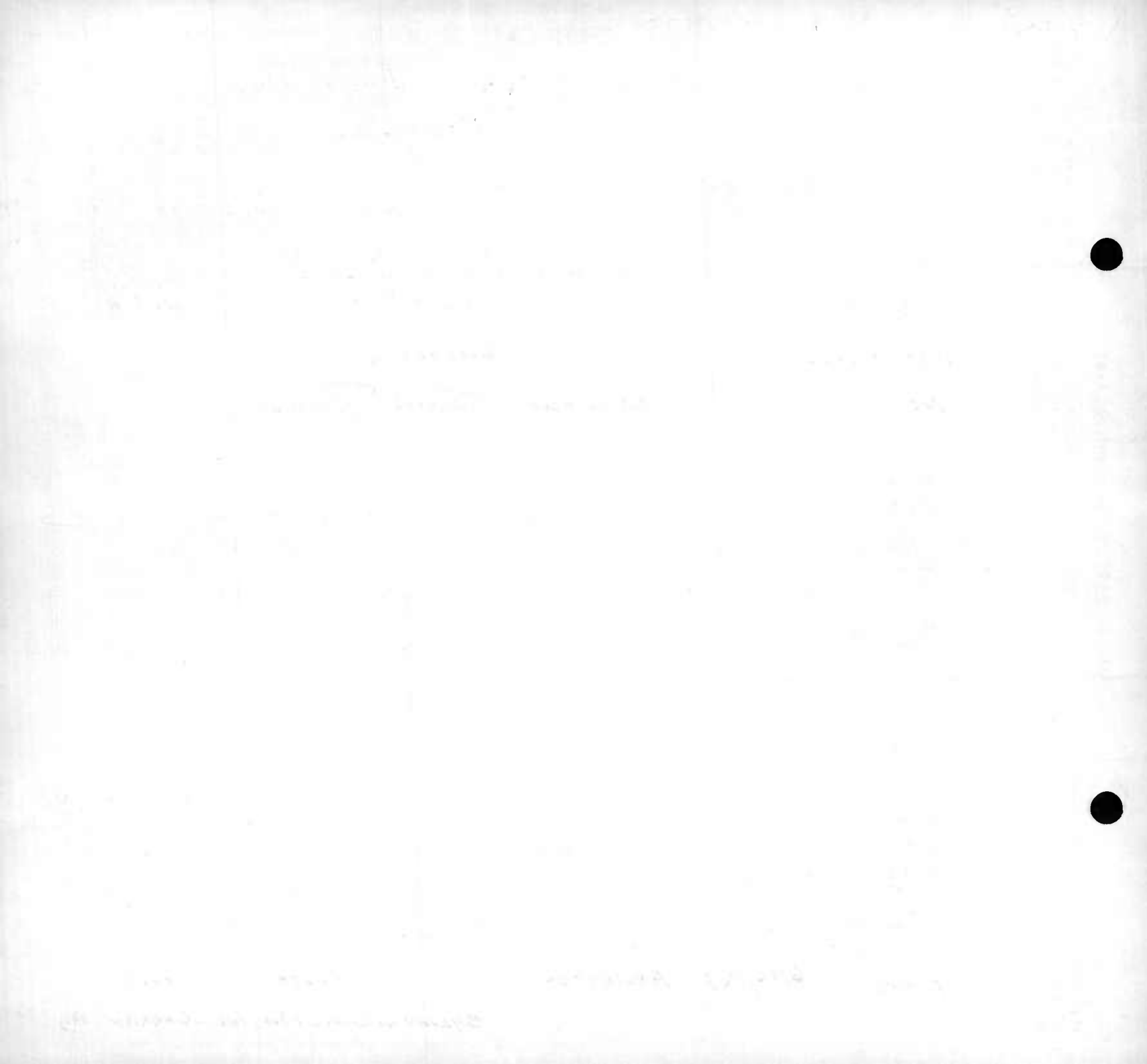
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67 6164					CERTIFICATE OF DEATH					Registered No. 67 6164				
1. NAME OF DECEASED (Type or Print) <b>HAROLD WEAVER</b>					2. DATE AND HOUR OF DEATH <b>6-23-67</b> <b>11 50</b> <b>P.M.</b>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A, STATE <b>Md</b> B, COUNTY <b>Balto</b>					5. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI Hosp of BALTO., INC</b>					C. STREET ADDRESS (If rural, give location) <b>2922 Manns Ave</b>					12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>		8. DATE OF BIRTH <b>2-20-13</b>		9. AGE (In years last birthday) <b>54</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jeweler</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>self-employed</b>					11. BIRTHPLACE (State or foreign country) <b>TENNA</b>				
13. FATHER'S NAME <b>Clyde H Weaver</b>					14. MOTHER'S MAIDEN NAME <b>Mary K Maser</b>					17. INFORMANT ADDRESS <b>hospital records</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>					16. SOCIAL SECURITY NO. <b>173-03-4737</b>									
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY INSUFFICIENCY</b>										INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <b>6-23-67</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>NO</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <b>6-22</b> <b>1967</b> to <b>6-23</b> <b>1967</b> , that (I) (we) last saw the deceased alive on <b>6-23</b> <b>1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>Ceslie Abramowitz</b>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>6-23-67</b>		
23C. PHYSICIAN'S NAME (Type) <b>Ceslie Abramowitz</b>								M.D. <b>SINAI Hosp of BALTO., INC.</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>				24B. DATE <b>6 26 67</b>		24C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>				25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>				25C. FUNERAL DIRECTOR <b>CHAS. F. EVANS &amp; SON, INC</b>				ADDRESS <b>8802 Harford Rd. Balto. Md</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
67 6165					CERTIFICATE OF DEATH					Registered No. 67 6165				
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <b>KELLERT MICHAEL</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-17</b>					2. DATE AND HOUR OF DEATH <b>JUNE 23, 1967</b> <b>10 45 P.</b> M.				
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP. OF BALT., INC.</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>					D. STREET ADDRESS (If rural, give location) <b>CEVINDACE NURSING HOME</b>				
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>		8. DATE OF BIRTH <b>8/30/85</b>		9. AGE (In years lost birthday) <b>81</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>					13. FATHER'S NAME <b>NOT KNOWN</b>					14. MOTHER'S MAIDEN NAME <b>ELIZABETH</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>218-36-0200</b>					17. INFORMANT ADDRESS <b>HOSPITAL RECORDS</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b>					CAUSE OF DEATH (A) DUE TO <b>ACUTE MYOCARDIAL INFARCTION</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS.</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b>					YEARS				
(C)														
II														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?								
22. I certify that (1) (this hospital) attended the deceased from <b>9 PM 6/23 1967</b> to <b>10 PM 6/23 1967</b> .			that (2) (we) last saw the deceased alive on <b>6/23 1967</b> and that in (my) (our) opinion death occurred on the date			and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.								
23A. SIGNATURE <b>J. Brett Lazar</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>6/23/67</b>				
23C. PHYSICIAN'S NAME (Typed) <b>J. BRETT LAZAR</b>					M.D. <b>SINAI HOSPITAL</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>6/26/1967</b>			24C. NAME OF CEMETERY or CREMATORY <b>ARLINGTON</b>			24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>SYLVAN J. LEWIS &amp; SON, INC. - GARRISON, MD</b>			ADDRESS					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6166		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6166	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Baby FRINK		
2. DATE AND HOUR OF DEATH 6/19/67 8:10 A.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 175 Abington Ave. 29 Md		
5. SEX M			6. RACE Negro		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) S			8. DATE OF BIRTH 6/19/67		
9. AGE (In years last birthday) 6			10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 6 20		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Abraham Johnson			14. MOTHER'S MAIDEN NAME Carolyn Frink		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Hospital Records			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH Partial separation of placenta		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Premature infant (2000 gm)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) Primary pulm. atelectasis		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-19-67 to 6-19-67, that (I) (we) last saw the deceased alive on 6-19-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aleyde A. Melocaton M.D.			23B. DATE SIGNED 6-19-67		
23C. PHYSICIAN'S NAME (Type) ALEYDE A. MELOCATON M.D.			23D. ADDRESS Bon Secours Hospital		
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 6/23/67		24C. NAME OF CEMETERY or CREMATORY St. Peter's	
24D. LOCATION (City, town, or county) Balto Md		24E. STATE		24F. ZIP CODE	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1967		25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR Thomas J. Kenny, Jr. Balto	
25D. ADDRESS		25E. PHONE NO.		25F. CITY, STATE, ZIP CODE	

11.8.1947

Robertson, Robert  
Cecil Frank

Robertson, Robert

Robertson, Robert  
Cecil Frank

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 6167				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6167	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				WILLIAM L. THOMPSON		10 <sup>PM</sup> 6/19/67 10 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				MARYLAND		B. COUNTY	
THE JOHNS HOPKINS HOSP				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		WALDORF	
				D. STREET ADDRESS (If rural, give location)		BOX 269 RT 1	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
M	N	Married	9-11-13	53	Farming	Charles County, Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ADRIAN THOMPSON				LENA PROCTOR			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
						William D. Thompson Rt. 1-Box 269 Waldorf, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) Pneumococcal meningitis		9 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
6/16/67		R/O hydrocephalus		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6/12/67 19 to 6/19/67 19 that (I) (we) last saw the deceased alive on 6/19/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
John S. Sergeant						6-19-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		M.D.			
John S. Sergeant		The Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		June 29/67		St. Mary's Ch. Cemetery		Bryantown, Chas. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 27 1967		Robert E. Taylor		Martell Adams		Aguasco, Md.	

Wm. L. Thompson

The John H. H. H.

A. W.

Adrian Thompson

LENA PROCTOR

9-11-13

Box 2nd RT 1

MADEIRA

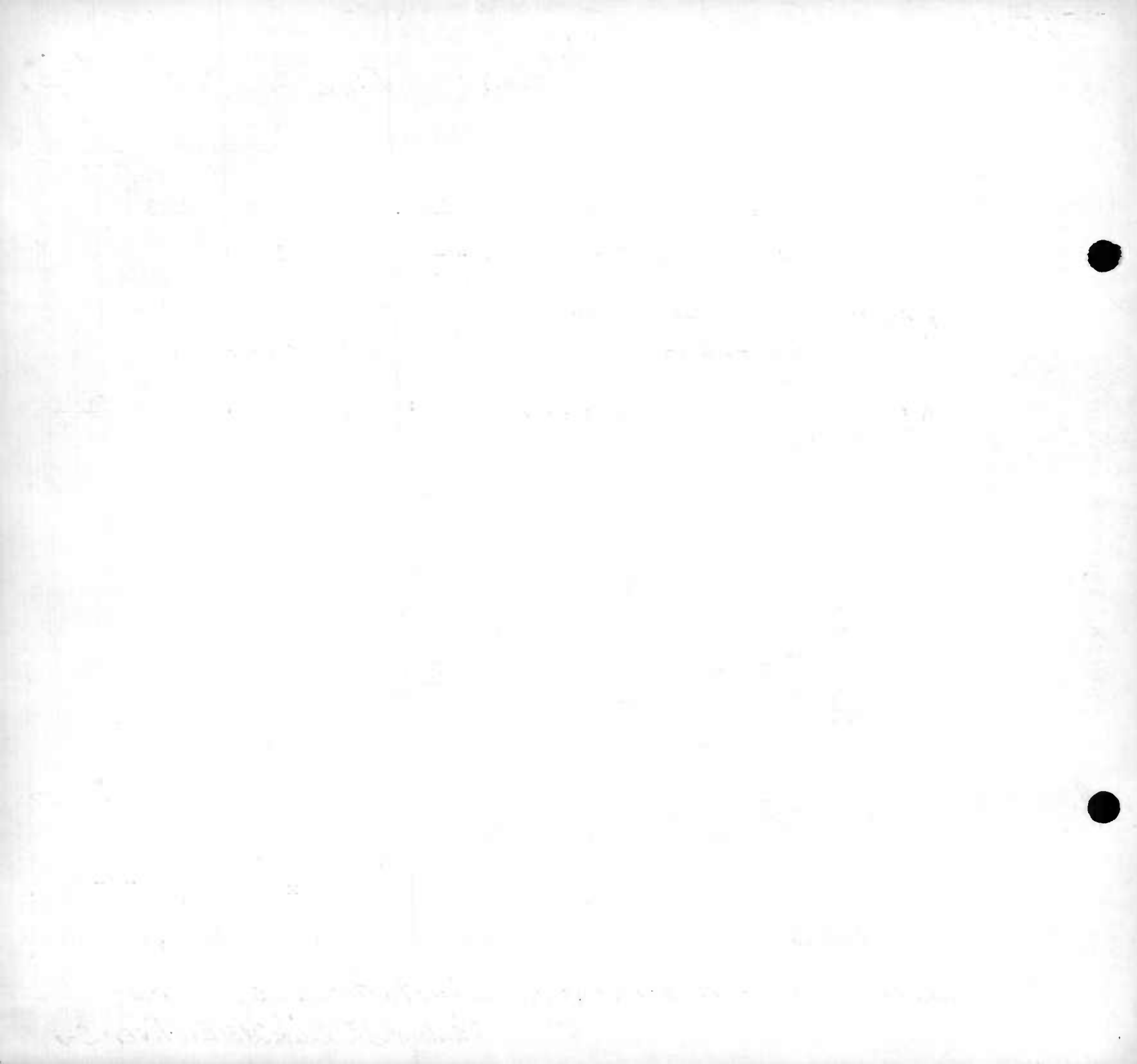
STANDARD

6-11-13

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

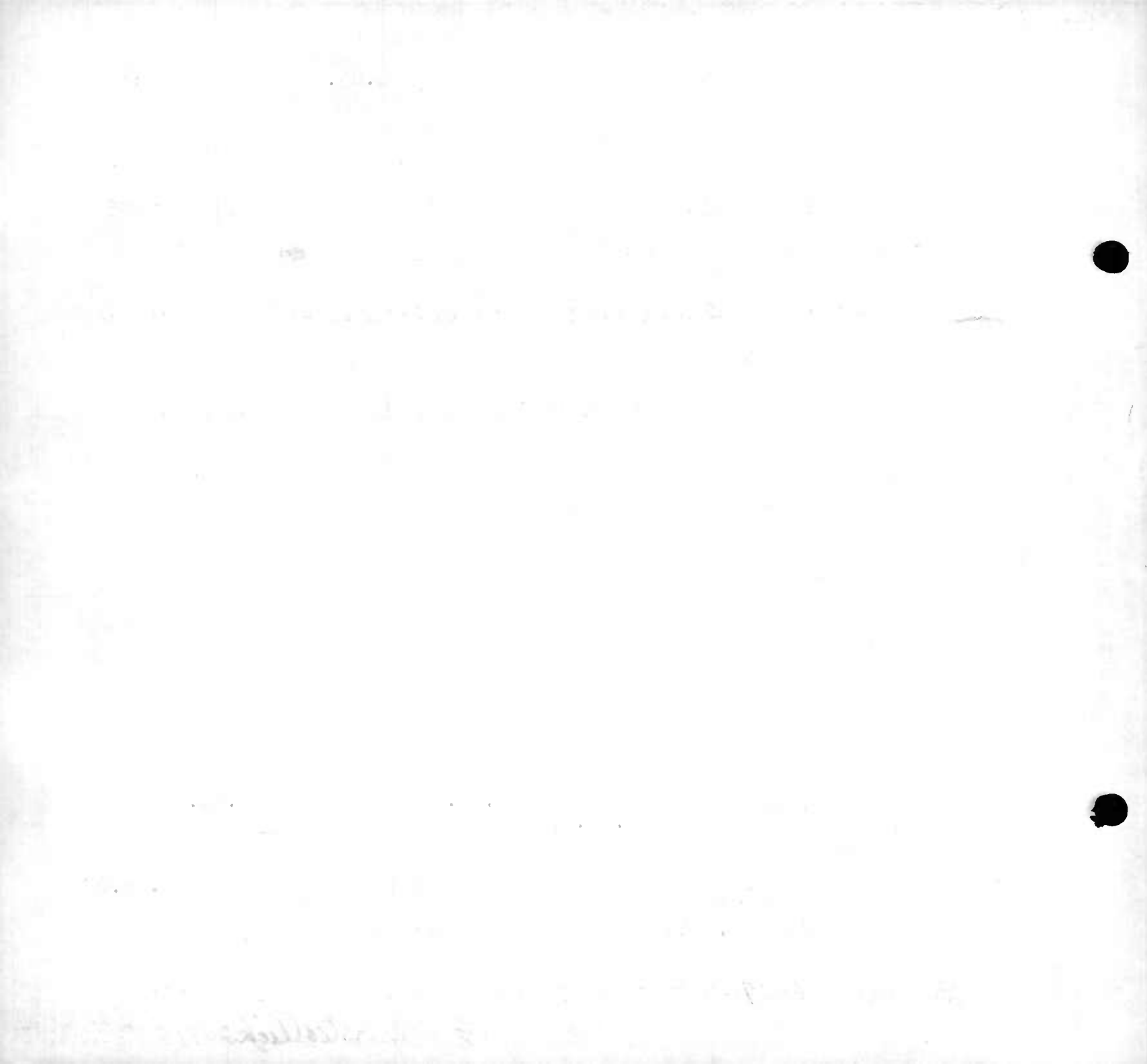
BALTIMORE CITY HEALTH DEPARTMENT				67 6168		CERTIFICATE OF DEATH		Registered No. 67 6168	
BIRTH NO.		67 6168		1. NAME OF DECEASED (Type or Print) <i>Grant, Archie</i> (ARCHIE GRANT)		2. DATE AND HOUR OF DEATH <i>June 21, 1967 12<sup>30</sup> P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>					
				D. STREET ADDRESS (If rural, give location) <b>1515 N. LUZERNE AVENUE #21213</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED <b>Married</b>		8. DATE OF BIRTH <b>10-3-13</b>		9. AGE (In years last birthday) <b>53</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Edward Grant</b>				14. MOTHER'S MAIDEN NAME <b>Annie Campbell</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>250-18-6691</b>		17. INFORMANT ADDRESS <b>BCH 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>493X I</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO <b>Pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>Pulmonary Embolus</b>				<b>few hours</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) _____					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>May 24, 1967</b> to <b>June 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 21, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Mary Ann Sullivan</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>6/21/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARY ANN SULLIVAN</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Maryland #24</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-26-67</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Pk. Arbutus, Md.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <i>R. S. Taylor</i>		25C. FUNERAL DIRECTOR <i>Randolph J. Collick</i>		25D. ADDRESS <b>2431 E. Oliver St.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 6169</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 6169</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Edward Green</b>			2. DATE AND HOUR OF DEATH <b>6.23.67 8:50PM</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1019 N WOLFE STREET 21205</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>8-15-09</b>	9. AGE (In years lost b.p.) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>		11. BIRTHPLACE (State or foreign country) <b>Jamestown, S.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>FRANK GREEN</b>		14. MOTHER'S MAIDEN NAME <b>MAGGIE SMALL</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>244-23-2968</b>		17. INFORMANT <b>Dorothy Green 1019 N. Wolfe</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH <b>Myocardial Infarction</b> (A) DUE TO (B) DUE TO (C) DUE TO  INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6.21.67</b> 19 to <b>6.23.67</b> 19, that (I) (we) lost saw the deceased alive on <b>6.23.67</b> 19 and that in (my) (our) apinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did nat) view the body after death.					
23A. SIGNATURE <b>Robert M. Winslow</b> M.D.				23B. DATE SIGNED <b>6.23.67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert M. Winslow</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-29-67</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Pk. Arbutus, Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <b>R. E. S. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Randolph Collick</b>		25D. ADDRESS <b>2431 E. Oliver St.</b>			

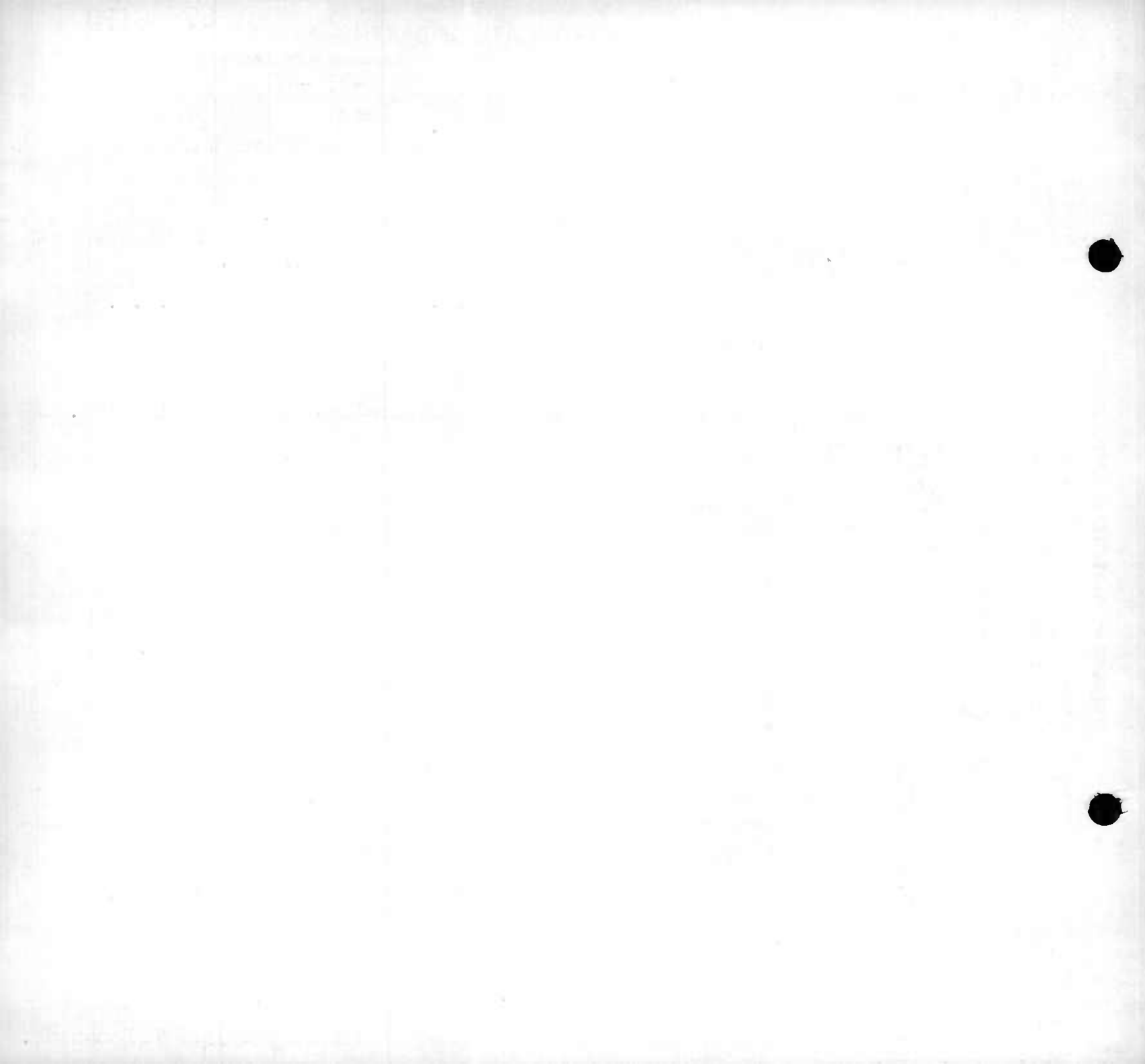




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6170		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6170	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mary Emma Spruill		2. DATE AND HOUR OF DEATH 6-25 -67 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 15-09			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kenson Nursing Home 2922 Arunah Avenue		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4130 Norfolk Ave.			
5. SEX Male	6. RACE Negroid	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 7-18-95	9. AGE (In years lost birthday) 71 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Solomon Need		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Flossie Walker 4130 Norfolk Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION (s).		(A) Cardiac-Vascular Disease Over a year. DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ✓					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 2, 1967 to June 25, 1967, that (I) (we) last saw the deceased alive on June 24, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank N. Ogden		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 26, 67	
23C. PHYSICIAN'S NAME (Type) FRANK N. OGDEN		23D. ADDRESS 2701 N. Calvert St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-29-67	24C. NAME of CEMETERY or CREMATORY Calvary Cem.		24D. LOCATION (City, town, or county) (State) Norfolk, Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1967		25B. NAME OF REGISTRAR R. E. E. Taylor		25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <b>67 6171</b>	
67 6171											
BIRTH NO.											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <b>LAWRENCE TURNER</b>					2. DATE AND HOUR OF DEATH <b>6-25-67 11:10 A.M.</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>VIRGINIA</b> B. COUNTY <b>PORTSMOUTH</b>						
FULL NAME OF (If not in hospital or institution, give street address or location) <b>THE JONAS HOPKINS HOSPITAL BALTIMORE, MD 21205</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>PORTSMOUTH</b>						
D. STREET ADDRESS (If rural, give location) <b>1007 COLONIAL AVE</b>											
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>DIVORCED</b>		8. DATE OF BIRTH <b>7-30-22</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>TRUCK LINES</b>		11. BIRTHPLACE (State or foreign country) <b>Southampton Co. Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>CROCKER TURNER</b>				14. MOTHER'S MAIDEN NAME <b>HATTIE STIFF</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Joe W. Turner</b>			ADDRESS <b>1007 Colonial St.</b>		
18. <b>330X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>INTRACRANIAL ANEURYSM - RUPTURED</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>6-24-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Anterior Communicating Artery</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>INJURY OCCUR?</b>		21C. HOW DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from <b>June 22 1967</b> to <b>June 25 1967</b> , that (I) (we) last saw the deceased alive on <b>June 25 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Ronald Brisman</b> M.D.										23B. DATE SIGNED <b>6-25-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>RONALD BRISMAN</b>										23D. ADDRESS M.D. <b>JO HNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-29-67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Roosevelt Mem. Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Chesapeake VA</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <b>Charles S. ...</b>		25C. FUNERAL DIRECTOR <b>Mortons Dyett F.H.</b>		ADDRESS <b>1701 LAURENS</b>					

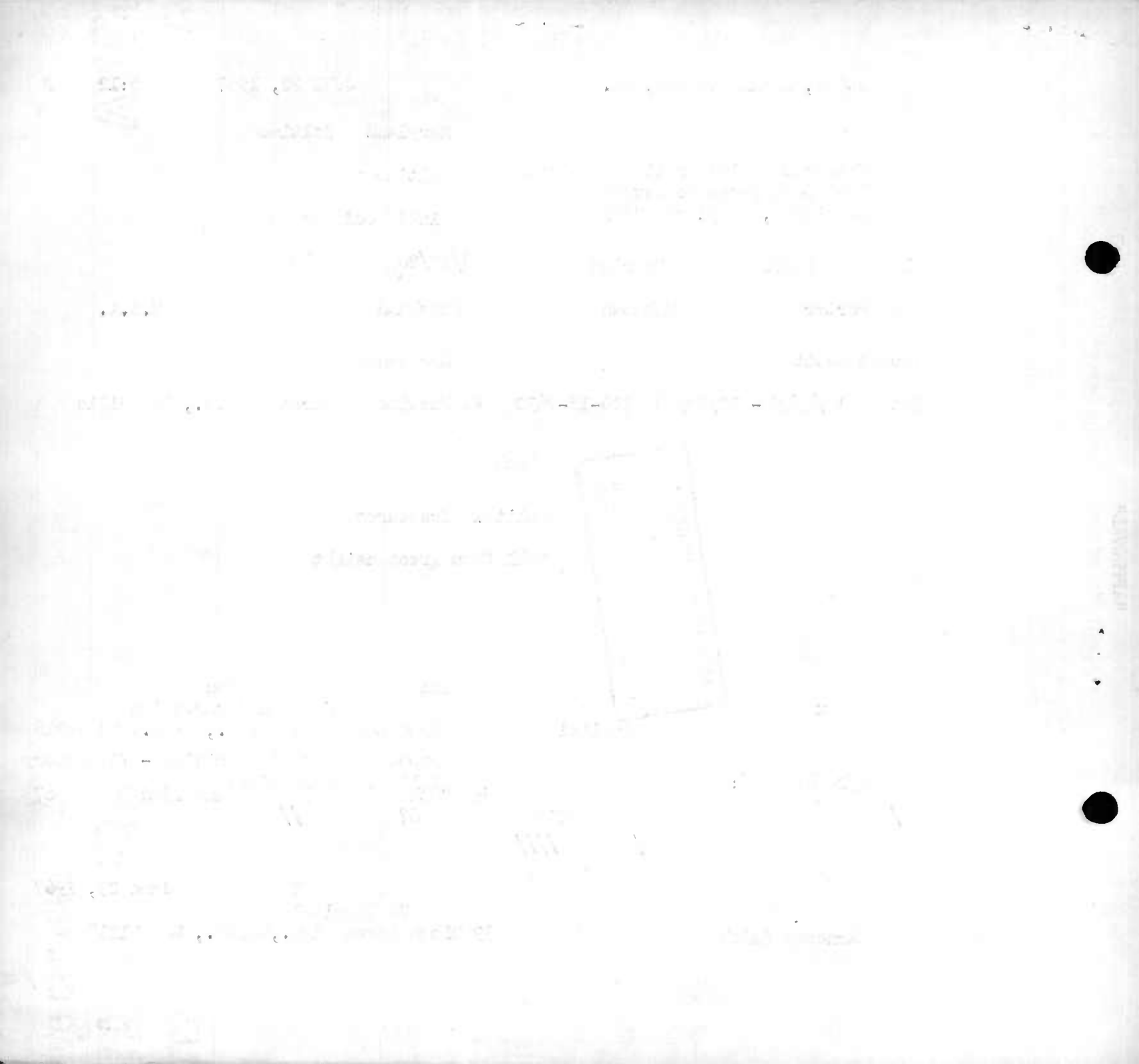


"APPROVAL"

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6172		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6172	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SCOTT, GERALD EUGENE, SR.		2. DATE AND HOUR OF DEATH JUNE 22, 1967 6:12 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1129 Woodyear St			16. AGE (In years last birthday) 40
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/22/26	9. AGE (In years last birthday) 40	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Porter
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Porter		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Scott		14. MOTHER'S MAIDEN NAME Mae Husen	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 220-18-9630		17. INFORMANT VA Hospital Records Balto., Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Shock		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION 6/22/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Federal Reservation 3900 Loch Raven Blvd., Balto., Md 21218	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 6/22/67 5:05 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Probable attempted suicide - five story fall to hard surface	
22. I certify that (1) (this hospital) attended the deceased from June 20th 19 67 to June 22nd 19 67, that (1) (we) last saw the deceased alive on June 22nd 19 67 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (4/11) view the body after death.		23A. SIGNATURE Ernesto Smith		23B. DATE SIGNED June 23, 1967	
23C. PHYSICIAN'S NAME (Type) Ernesto Smith		23D. ADDRESS VA Hospital 3900 Loch Raven Blvd., Balto., Md 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-26-67		24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l Cem.	
24D. LOCATION Balto.		24E. LOCATION (City, town, or county) Balto.		24F. LOCATION (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Morton E. Dyett	
25D. ADDRESS 1701 Laurens					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6173				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6173	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Elizabeth J Brown		6/25/67 1:45 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
33 Johns Hopkins Hospital Baltimore Md.				Md. Baltimore 16-07			
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
F C Married				Baltimore			
8. DATE OF BIRTH 9. AGE (In years lost birthday)				D. STREET ADDRESS (If rural, give location)			
7/1/16 50				2821 Pressman ST.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Practical Nurse				Monroe, La.			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				U.S.A.			
LORIE Johnston				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				17. INFORMANT ADDRESS			
16. SOCIAL SECURITY NO.				Mr. Jimmie Brown 2821 Pressman			
433-34-8596				18. CAUSE OF DEATH			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)				INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				1 month			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				None -			
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
LAST Op - 1966 Adrenalectomy - Ca Breast				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/1 19 67 to 6/25 19 67, that (I) (we) last saw the deceased alive on 6/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE 23B. DATE SIGNED			
A.F. Brooker Jr. M.D.				6/25/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
A.F. Brooker Jr.				Johns Hopkins Hospital Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				6-25-67			
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Arbutus Mem. Park Balto.				Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
JUN 27 1967				MORTON E. Dyett F.H.			
25C. FUNERAL DIRECTOR				ADDRESS			
1701 LAURENS							

10/1/62  
10/1/62  
10/1/62

10/1/62  
10/1/62  
10/1/62

Major Henderson

Major Johnston

Respiratory Arrest  
Cerebral Edema  
Metastatic Breast Carcinoma

10/1/62  
10/1/62  
10/1/62

10/1/62  
10/1/62  
10/1/62



# FUNERAL DIRECTOR: IMPORTANT

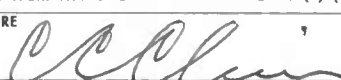
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

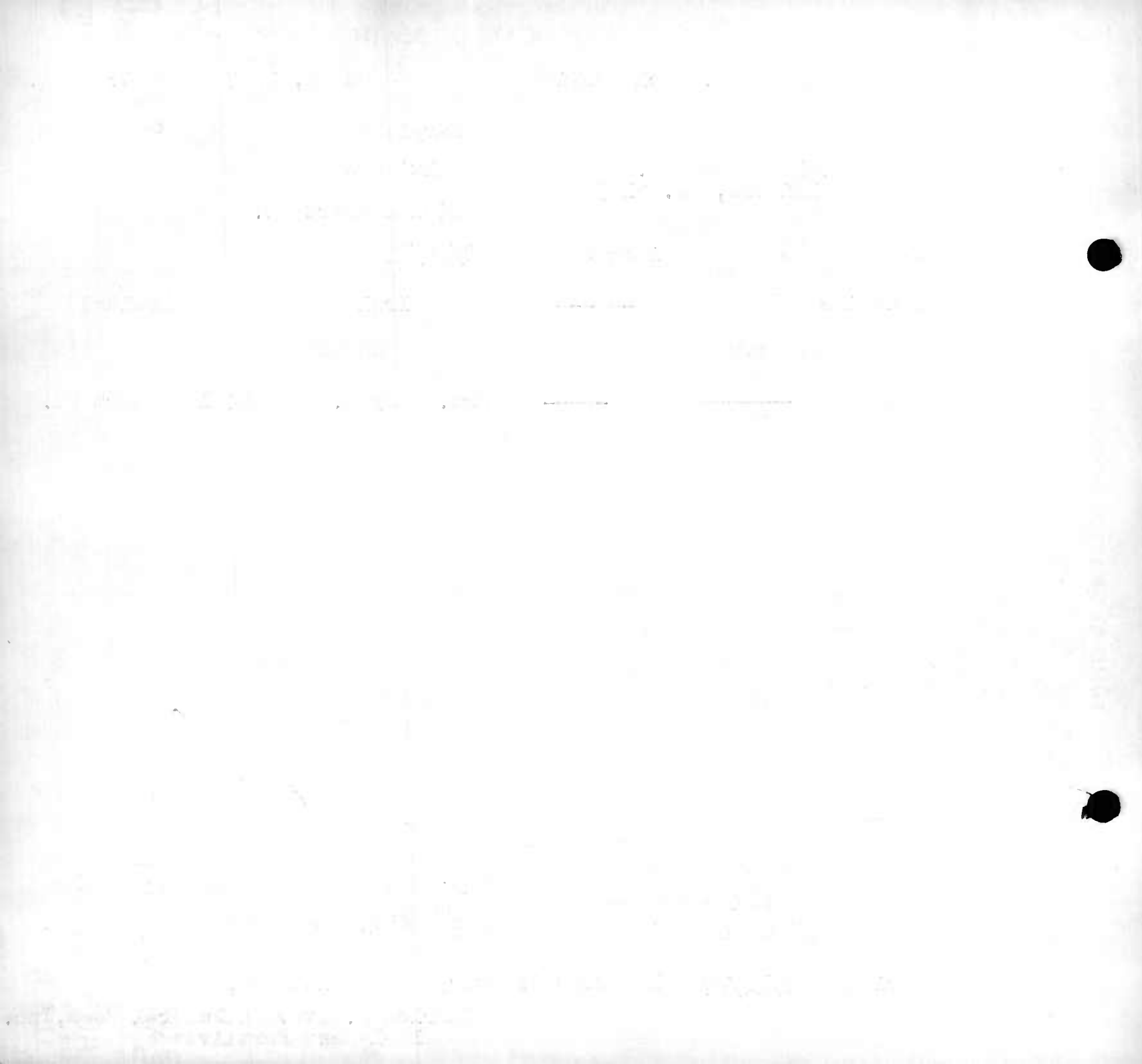
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6174</b>	
BIRTH NO. <b>67 6174</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MARY SCHAFER</b>		2. DATE AND HOUR OF DEATH <b>6/25/67 12 30 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>24-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MONTE BELLO STATE HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>1513 E. FORT AVE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>9/11/98</b>	9. AGE (in years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NA</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EDW. JAMES SCHAFER</b>		14. MOTHER'S MAIDEN NAME <b>MARY CAA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MONTEBELLO Admission DATA.</b>	
18. <b>722.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Anteriosclerotic Cardiovascular 20 yrs.</b> <b>Disease, Generalized, &amp; Discrete Myelitis, + Stasis Ulcers</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Pulmonary Embolus</b>		<b>12 Hrs.</b>	
19A. DATE OF OPERATION <b>NA</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>		20A. AUTOPSY: Yes or No <b>1</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) <b>NA</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <b>NA</b>		22. I certify that (I) (this hospital) attended the deceased from <b>6-22-67</b> 19 to <b>6-25-</b> 19 <b>67</b> , that (I) ( <del>was</del> ) lost saw the deceased alive on <b>6-25-</b> 19 <b>67</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) (did) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <b>Bernard S. Karpens Jr.</b> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-25-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>BERNARD S. KARPENS JR.</b>		23D. ADDRESS <b>MONTEBELLO STATE HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/25/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <b>P. G. E. [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Charles L. Stevens Funeral Home</b>		ADDRESS <b>1501 E. FORT AVENUE</b>			

1947/1948 150/1002

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6175</b>	
BIRTH NO. <b>67 6175</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Ellen A. McLaughlin</b>		2. DATE AND HOUR OF DEATH <b>June 21, 1967 7:45 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1401 Haubert St. Baltimore, Md. 21230</b>		A. STATE <b>Maryland</b> B. COUNTY <b>24-01</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>1401 Haubert St.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>8/15/81</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Ireland</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT ADDRESS <b>Mrs. Mary E. Wood 1401 Haubert St.</b>	
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Anteriosclerosis heart disease</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>yes</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>---</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>---</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>---</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>---</b>	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>JUNE 1967</b> to <b>June 21-1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>JUNE 10<sup>th</sup></b> 19 <b>67</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6-23-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>C.C. CHIU</b>		23D. ADDRESS M.D. <b>1 E. RANDALL ST. Balto. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/24/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>			
25B. NAME OF REGISTRAR <b>Charles L. Stevens</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-11741 67 6176		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6176	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Schreiner		2. DATE AND HOUR OF DEATH 6/18/67 12:17 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) nm	
8. DATE OF BIRTH 6/17/67		9. AGE (In years last birthday) 1		10. Under 1 Yr. Months: Days: 15 Hours: 0	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Schreiner		14. MOTHER'S MAIDEN NAME Patricia Leonard	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mercy Hospital Records	
18. 760.571 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CHS bleed (B) Hyaline Membrane DUE TO		INTERVAL BETWEEN ONSET AND DEATH 29 hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO (C) prematurely					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/17/67 to 6/18/67, that (I) (we) last saw the deceased alive on 6/18/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE W E Schwarz		23B. DATE SIGNED 6/18/67	
23C. PHYSICIAN'S NAME (Type) W E Schwarz		23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/67		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, of county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 27 1967		25B. NAME OF REGISTRAR Charles E. Stevens	
25C. FUNERAL DIRECTOR Charles E. Stevens		25D. ADDRESS 1501 E. Fort Ave.			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Raymond J. CLARK

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1967

9:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1412 South Hanover Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, with RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1412 South Hanover Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

May 29, 1922

9. AGE (in years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Auto Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S. A.

13. FATHER'S NAME

James Clark

14. MOTHER'S MAIDEN NAME

Louise Finn

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL  
SECURITY NO.

213-12-6795

17. INFORMANT

ADDRESS

Mrs. Eileen Furlotti 407 S. Wickham Rd

18. 795.3

CAUSE OF DEATH

Cause of death undetermined because  
of postmortem decompositionINTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 17, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/21/67

23C. NAME OF CEMETERY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

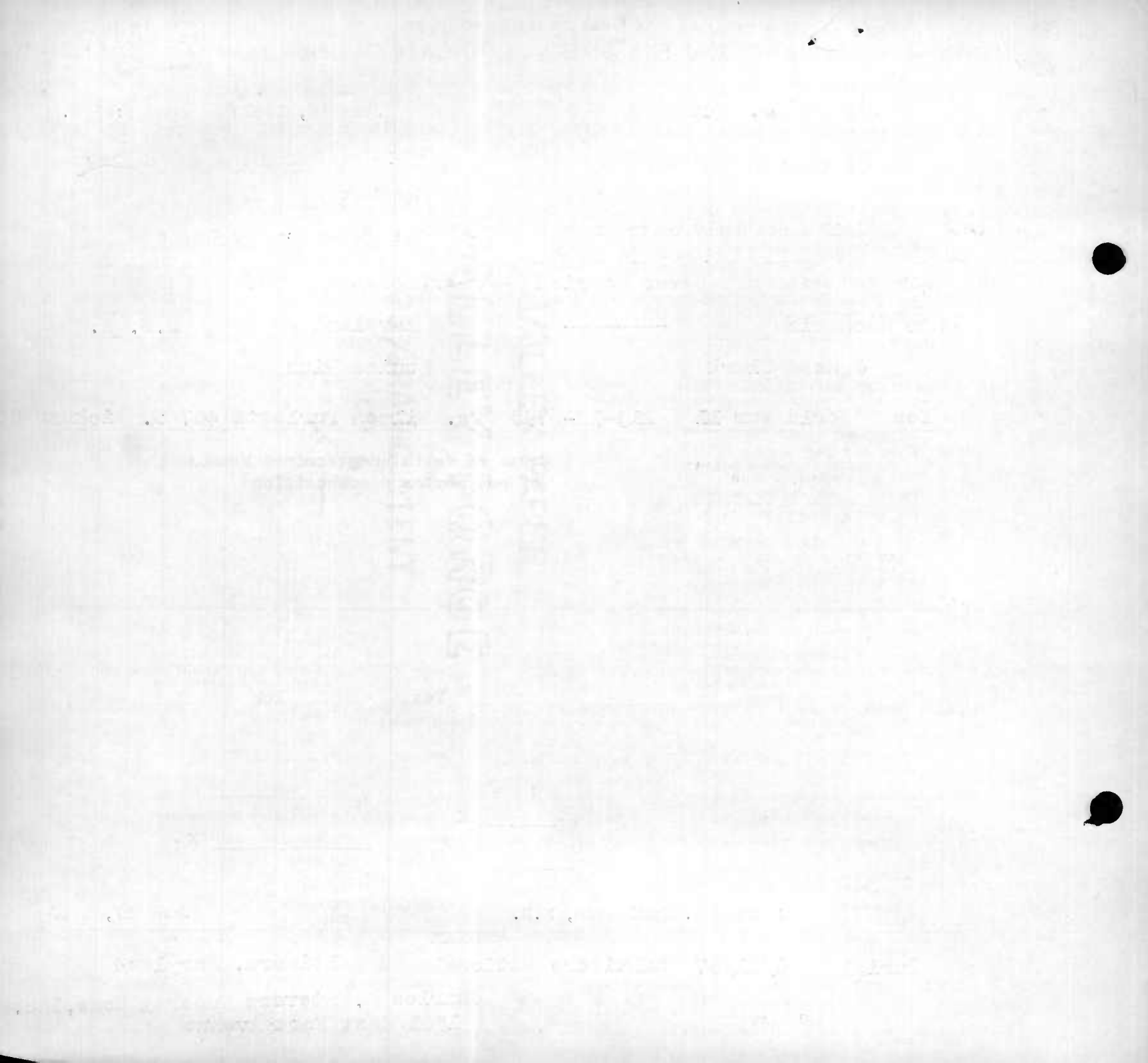
24C. FUNERAL DIRECTOR

ADDRESS

JUN 27 1967

Charles E. Springate

Charles L. Stevens Funeral Home, Inc.  
1501 East Fort Avenue

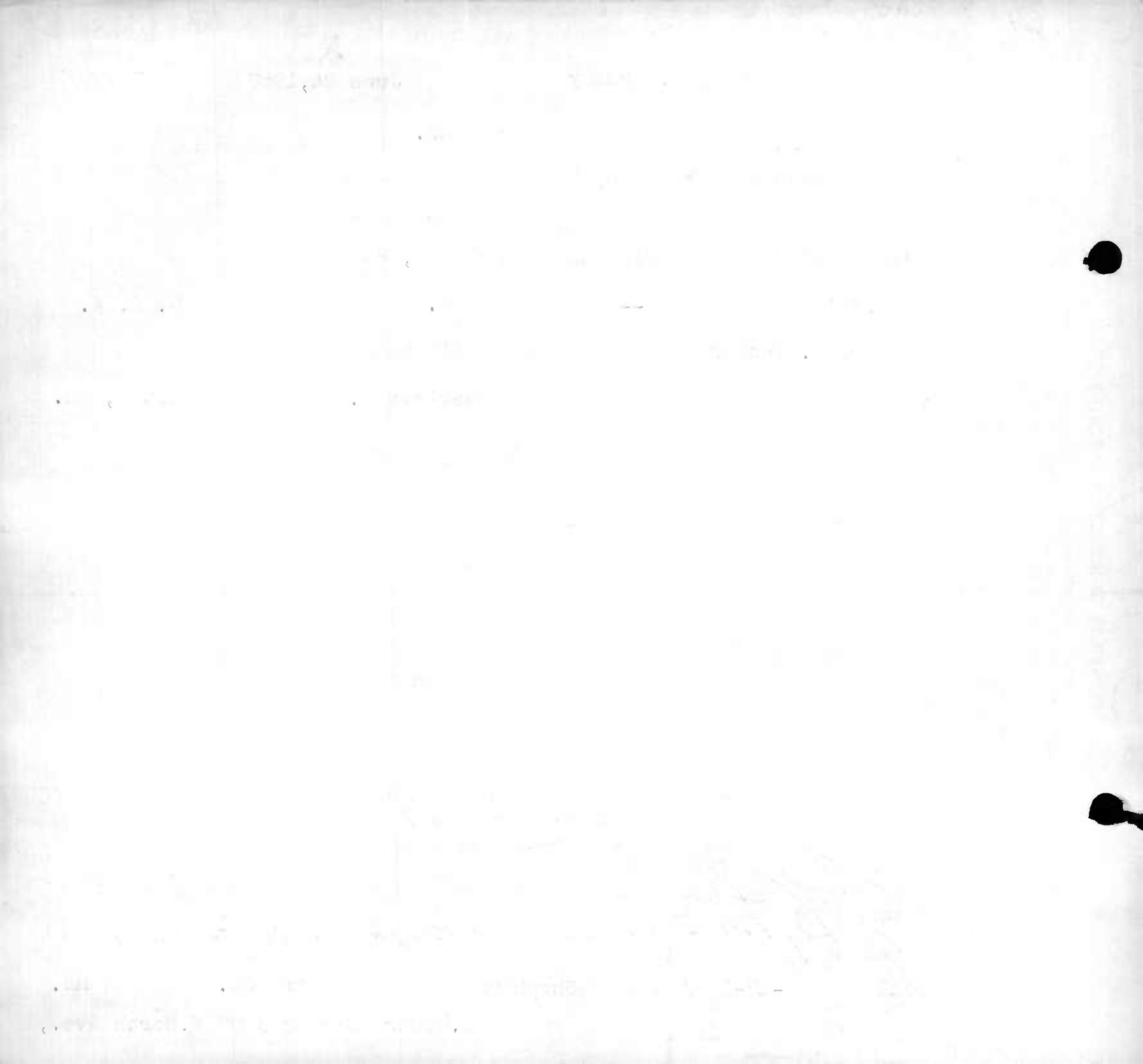




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6178		CERTIFICATE OF DEATH		67 6178	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Margaret W. Crosby		June 24, 1967		2:10 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE			
		B. COUNTY			
Harford Gardens Convalescing Home		Md.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Fallston			
		D. STREET ADDRESS (If rural, give location)			
		Box 352			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
Female	White	Widowed	July 15, 1895	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		--		Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Robert L. Tucker			Elizabeth Hobbs		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Genevieve L. Durdning Fallston, Md.	
18. 592X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
		Chronic Nephritis		1 year	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 14 19 67 to June 24 19 67, that (I) (we) last saw the deceased alive on June 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Loy M. Zimmerman</i>				23B. DATE SIGNED June 25, 67	
23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman M.D.				23D. ADDRESS 3202 Harford Rd Baltimore Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-27-1967		Good Shepherd	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 27 1967		Robert E. Taylor M.D.		G. Howard Strong 3207 W. North Ave.,	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 6179		CERTIFICATE OF DEATH		Registered No. 67 6179	
1. NAME OF DECEASED (Type or Print) <b>BRANCH CATHERINE (Lewis)</b>				2. DATE AND HOUR OF DEATH <b>JUNE 23-67 10<sup>00</sup> P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital (Balto.)</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>16-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1203 W. LANVALE ST.</b>					
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SEP</b>		8. DATE OF BIRTH <b>10/10/40</b>	9. AGE (In years lost birthday) <b>26</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Smithfield, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Lewis Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Lewis</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212-36-6309</b>		17. INFORMANT <b>Mrs. Daisy Jeter</b>		ADDRESS <b>1614 Riggs Ave</b>	
18. <b>456X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Hypertension + Uremia</b> DUE TO (B) <b>Systemic Lupus Erythematosus</b> DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>6/23</b> 19 <b>65</b> to <b>6/23</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/23</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Ruth P. Sligar</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Ruth P. Sligar</b>		23D. ADDRESS <b>UNIVERSITY HOSP - MD.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-28-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F.H.</b>		ADDRESS <b>1701 LAURENS ST.</b>			



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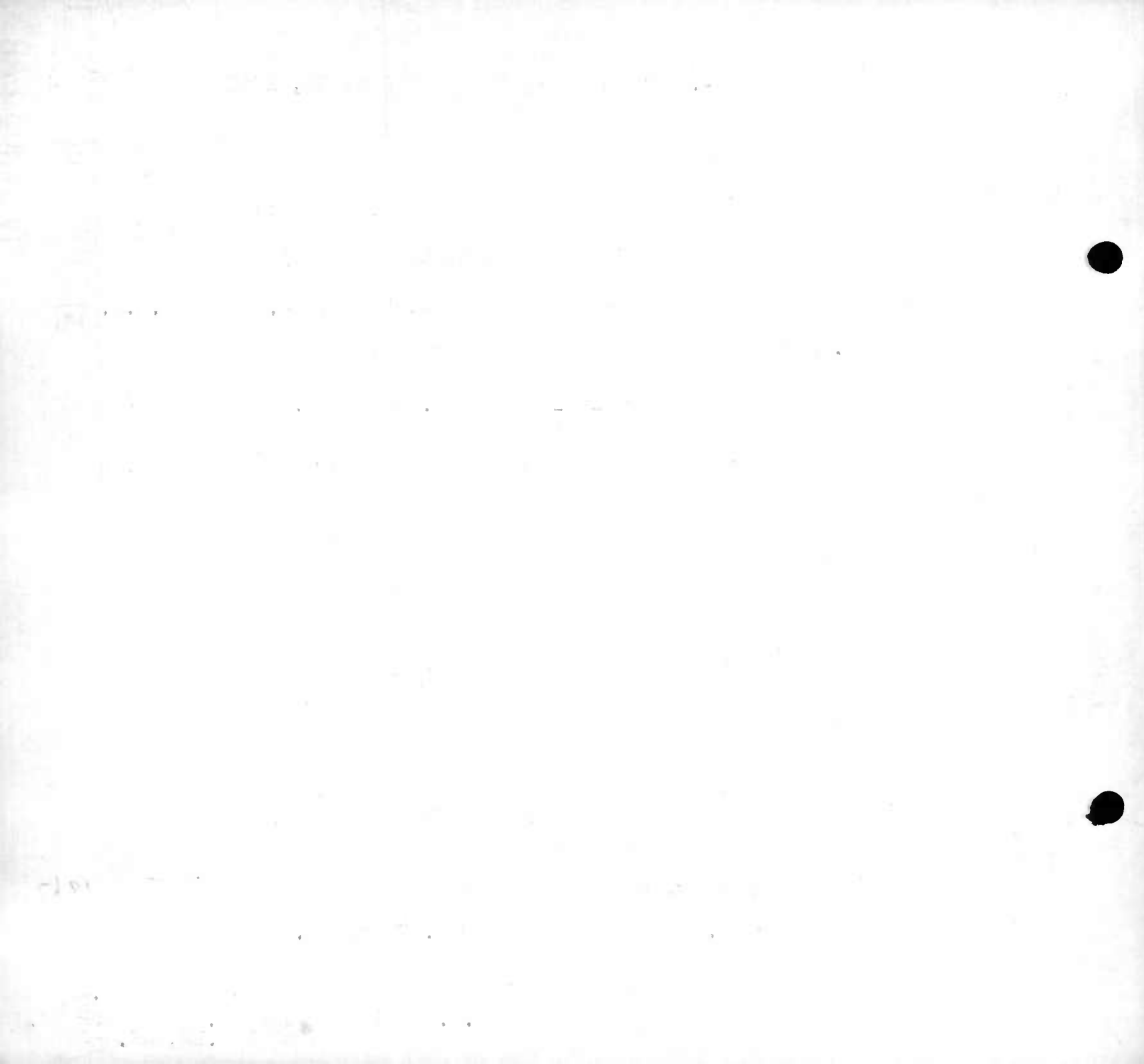
BIRTH NO. 67 6180				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6180	
M.E. CASE NO.				HAMDON		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)				Eva Hamilton Chapman		June 25, 1967 4:25 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
<div style="text-align: center;"> <b>CERTIFICATE AMENDED</b>  <small>FULL NAME OF HOSPITAL OR INSTITUTION</small>                      (If not in hospital or institution, give street address or location)                 </div>				Maryland		7-05	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
D. STREET ADDRESS (If rural, give location)				3213 Tinges Lane			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
F	W	Never Married	2-8-1888	79			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Clerk		Stationers		Md.		USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			ADDRESS	
Robert Breckinridge Chapman			Belinda Hayes				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		
No			215-01-7433		33 Robert B. Chapman 5400 Willowmere Way		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <i>Arteriosclerotic Heart Disease</i>		1 Hour	
				(B) <i>Generalized Arteriosclerosis</i>			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<i>Parkinsonism</i>		8 YEARS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>AUGUST 7 1959</i> to <i>JUNE 25 1967</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>Nov. 22 1966</i> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did)</del> <del>(did not)</del> view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
<i>John M. Scott</i>						<i>JUNE 26, 1967</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
JOHN M. SCOTT		M.D. 600 W. BELVEDERE AVE. BALTIMORE, MD 21210					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-29-67		Mt. Paran Presbyterian		Harrisonville Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 27 1967		<i>Robert E. Stacey M.D.</i>		H.W. Jenkins & Sons Co.		4905 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 6181</span>	
BIRTH NO. <span style="float: right;">67 6181</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Harry A. Murphy		June 26, 1967 12:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
4415 Bedford Place		Maryland 27-11			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		4415 Bedford Place			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
M	W	Married	3/12/1884	83	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Furniture Business		Baltimore, Md.	U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Frank J. Murphy			Mary Casey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218-16-2344		Mrs. Marion F. Murphy (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) <u>Atherosclerotic heart disease</u> 2 yrs			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) <del>(the hospital)</del> attended the deceased from 19 <u>55</u> to <u>date</u> 19 <u>67</u> , that (I) <del>(we)</del> lost saw the deceased alive on <u>20 June</u> 19 <u>67</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<u>Robert E. Mason</u> M.D.				26 June 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Robert E. Mason		9 E. Chase St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/28/67		New Cathedral	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Baltimore, Md.		JUN 27 1967		<u>Robert E. Jenkins</u>	
25A. FUNERAL DIRECTOR ADDRESS		25B. NAME OF REGISTRAR			
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					





FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">67 6182</span>	
BIRTH NO. <span style="font-size: 1.2em;">67 6182</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Anne Voorhees McKim</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">6/24/1967</span> <span style="font-size: 1.1em;">5:10 A.M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.1em;">Hillcrest Nursing Home</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.1em;">11-03</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.1em;">Baltimore</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.1em;">212 W. Read St.</span>		
5. SEX <span style="font-size: 1.1em;">F</span>	6. RACE <span style="font-size: 1.1em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.1em;">Divorced</span>	8. DATE OF BIRTH <span style="font-size: 1.1em;">1/11/1878</span>	9. AGE (In years last birthday) <span style="font-size: 1.1em;">89</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Retired-</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.1em;">Antique Business</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Baltimore, Md.</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.1em;">Hollins McKim</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Eliza Frances Voorhees</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">No</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">214-44-9836</span>			17. INFORMANT ADDRESS <span style="font-size: 1.1em;">Mrs. N. Smith Pendleton 3820 Roland Ave</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.1em;">15-1X I</span> <span style="font-size: 1.1em;">Carcinoma of stomach</span>			INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.1em;">6 wks</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.1em;">A-S H. D</span>			<span style="font-size: 1.1em;">2 yrs.</span>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <span style="font-size: 1.1em;">3/28</span> 1967 to <span style="font-size: 1.1em;">6/24</span> 1967, that (I) <del>(we)</del> last saw the deceased alive on <span style="font-size: 1.1em;">6/20</span> 1967 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did not)</del> view the body after death.					
23A. SIGNATURE <span style="font-size: 1.1em;">Norman R. Freeman, Jr.</span>				23B. DATE SIGNED <span style="font-size: 1.1em;">6/26/67</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">Norman R. Freeman, Jr. M.D.</span>				23D. ADDRESS <span style="font-size: 1.1em;">11 W. 29th St.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">6/27/67</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.1em;">Greenmount</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">JUN 27 1967</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">H.W. Jenkins &amp; Sons Co.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.1em;">4905 York Rd. Balto. 12, Md.</span>			

30101 YALU

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67-12163		67 6188		CERTIFICATE OF DEATH			Registered No. 67 6188		
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Baby Giel Johnson			2. DATE AND HOUR OF DEATH 6/25/67 902A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital				A. STATE Maryland		B. COUNTY ANN Arundel		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ANNAPOLIS 52-10	
D. STREET ADDRESS (If rural, give location) 201 West St.				5. SEX F		6. RACE N N		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) No	
8. DATE OF BIRTH 6/25/67		9. AGE (In years last birthday) 4		10. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) N/A		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Carolyn Johnson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 773.5T DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO Cardiac Arrest 10 minutes				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.)				(B) DUE TO Respiratory Arrest 4 hrs					
(C) DUE TO Prematurity									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. No									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/25 1967 to 6/25 1967 that (I) (we) lost saw the deceased alive on 6/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE James B. Brayton M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/25			
23C. PHYSICIAN'S NAME (Type) James B. Brayton				23D. ADDRESS Johns Hopkins Hosp. M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 6-25-67		24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS HOSPITAL		24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-13076</u> <u>67 6184</u>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <u>67 6184</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Johnson</u>		2. DATE AND HOUR OF DEATH <u>6/25/67</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>BA</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>4716 E. Lafayette AVE</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>N/A</u>	8. DATE OF BIRTH <u>6/24/67</u>	9. AGE (In years, last birthday) <u>8</u>	10. If Under 1 Yr. Months Days <u>30</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>MELINDA Johnson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARDIAC ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HYALINE MEMBRANE DISEASE 8 hrs</u> <u>SEVERE prematurity 6 hrs</u>		INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>NONE</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> 19 <u>67</u> to <u>6/25</u> 19 <u>67</u> . that (I) (we) last saw the deceased alive on <u>6/25</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James B. Brayton</u> M.D.		23B. DATE SIGNED <u>6/25/67</u>		23C. PHYSICIAN'S NAME (Type) <u>James B. Brayton</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>6-25-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS HOSPITAL</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 27 1967</u>			
25B. NAME OF REGISTRAR <u>John E. Taylor</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>			

James B. Braxton  
James B. Braxton

James B. Braxton  
James B. Braxton

6/22 6/22

Yes

None

Severe pneumonia

Hypertension

Cardiac arrest

No

Yes

Unknown

Yes

Myocardial

Yes

Yes

Yes

Myocardial

Myocardial

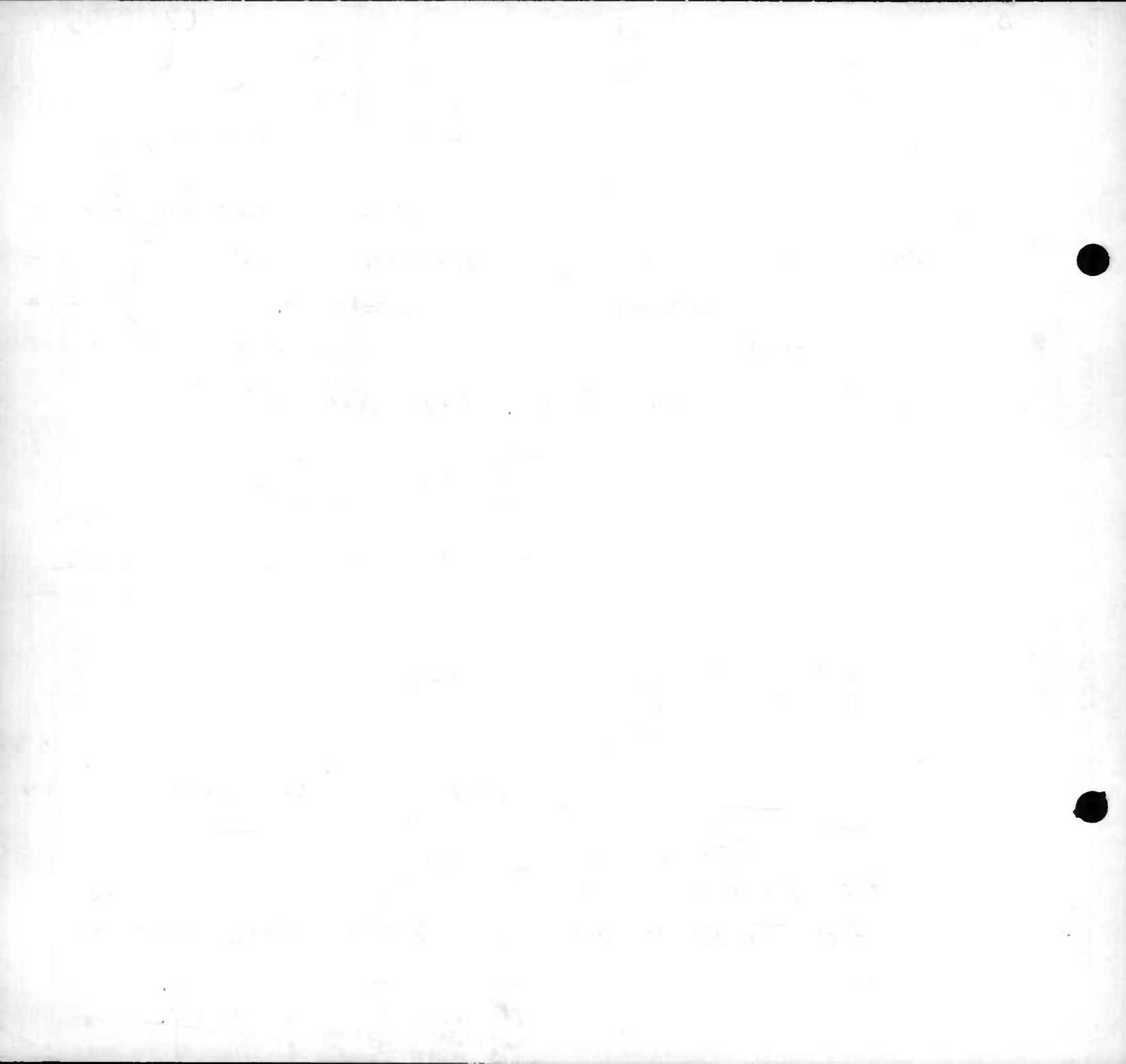
Myocardial

3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6185					67 6185				
BIRTH NO.					Registered No.				
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>James Sherman Hill</i>					<b>2. DATE AND HOUR OF DEATH</b> <i>6/25/67 7:50 pm</i>				
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <div style="text-align: center;">UNIVERSITY HOSPITAL</div>					<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Reisterstown</i> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <i>53-00</i> <b>D. STREET ADDRESS</b> (If rural, give location) <i>Box 63 Reisterstown, Md.</i>				
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>9/24/1891</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
			Retired		Fulton County PA.		USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
- Mose Hill			- Amanda Truax						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			196 09 7852 A.		Box 63 Reisterstown Maryland				
18. <i>420.11</i>					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) DUE TO				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					ATHERO-SCLEROTIC CORONARY ARTERY DISEASE WITH RECENT AND OLD MYOCARDIAL INFARCTION			1 WEEK	
ANTECEDENT CAUSES					(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) MESENTERIC THROMBOSIS			1 WEEK	
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>6/24</i> 19 <i>67</i> to <i>6/25</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6/25</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
<i>P.P. Toskes / Singleton M.D.</i>					<i>6/25/67</i>				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
<i>P.P. Toskes / Singleton M.D.</i>					<i>Univ. Hosp - Balto</i>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		<i>6/29/67</i>		Pleasant Ridge Cemetery		Needmore Pa.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<i>JUN 27 1967</i>		<i>Robert E. Farley</i>		HENRY SANDER & SONS INC.		BALTIMORE MARYLAND			





67 6186

BALTIMORE CITY HEALTH DEPARTMENT

67 6186

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FREDERICK J. SCHAFFER

2. DATE AND HOUR PRONOUNCED DEAD

6-25-67

3:00 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1513 E. Fort Avenue 21230

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

10-2-1901

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Lucas Brothers

10B. KIND OF BUSINESS OR INDUSTRY

Shipping Clerk

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward James Schaffer

14. MOTHER'S MAIDEN NAME

Mary Coa

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-09-8423

17. INFORMANT

ADDRESS

Annie Schaffer 1513 E. Fort Ave

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Russell S. Fisher

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-26-67

EXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/28/67

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 27 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Charles L. Stevens Funeral Home, Inc.

ADDRESS

1501 E. Fort Avenue

Mr. J. H. ...  
Lucus Brothers Shipping Co.  
Chicago, Ill.  
New York 10-2-1901

FORGE

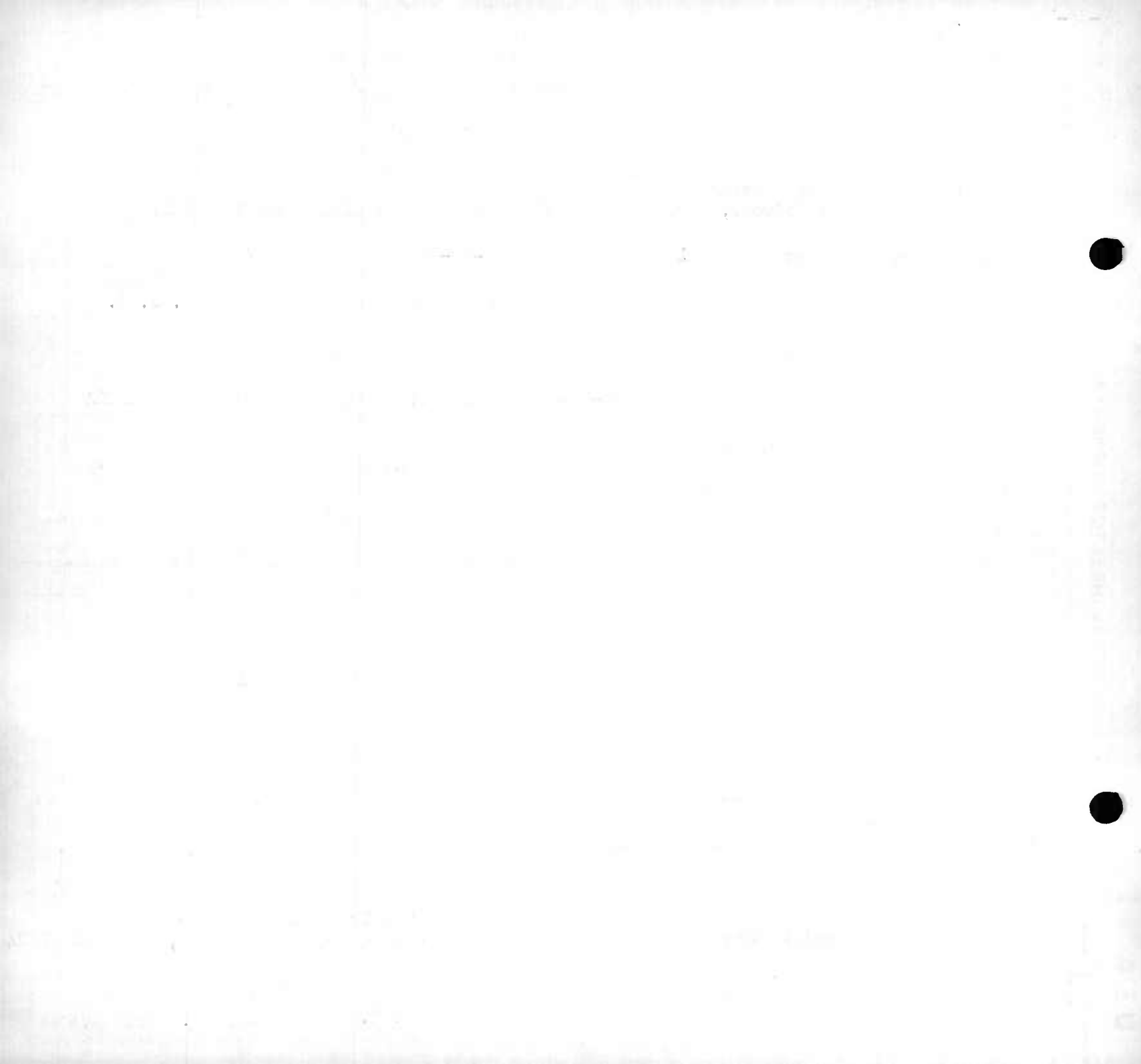
1701 E. ...  
Chicago, Ill.  
New York 10-2-1901

49-25-74  
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

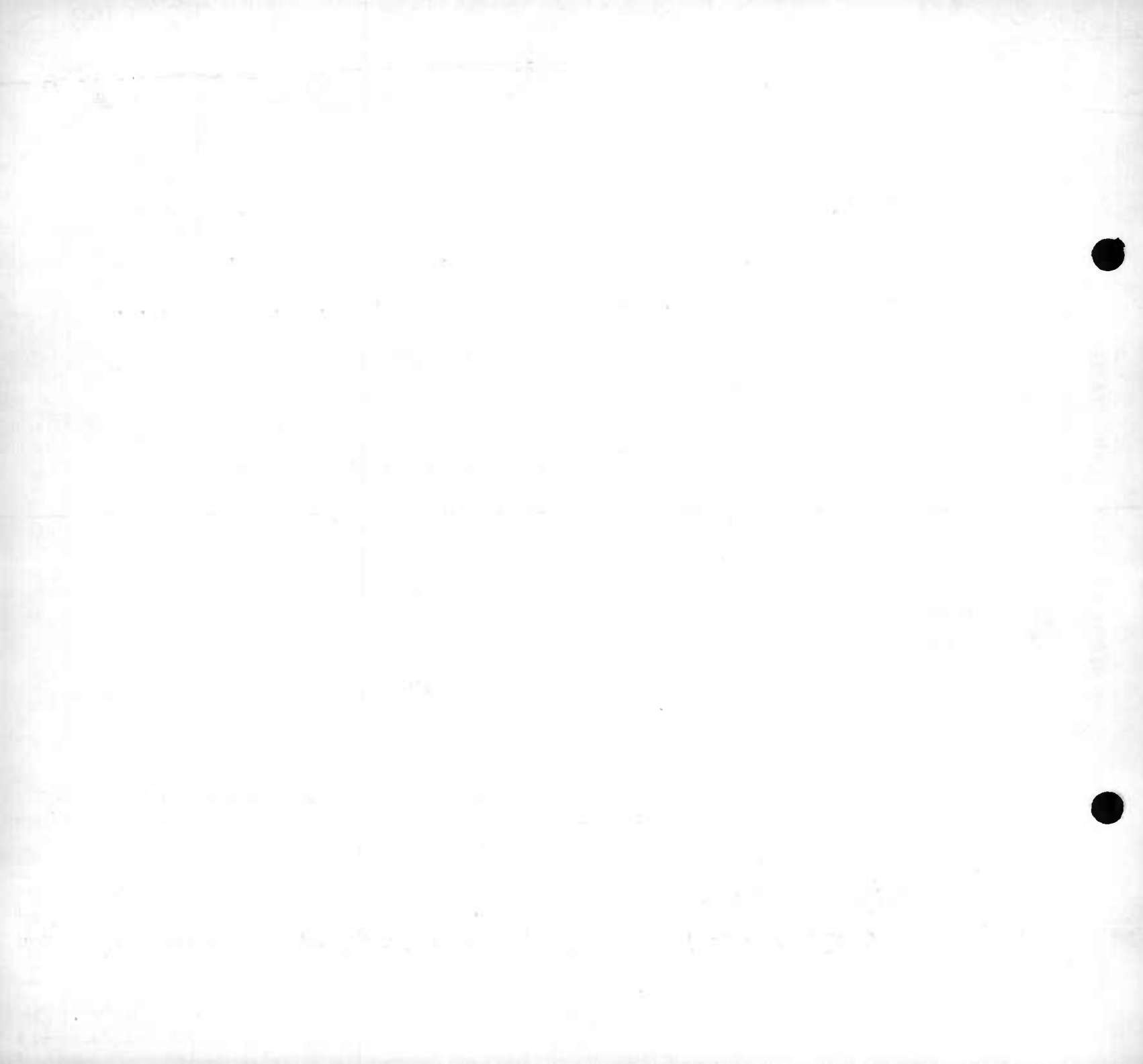
BIRTH NO. 67 6187				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6187	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				HELEN SHORGER		JUNE 25 1967 8 30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
				D. STREET ADDRESS (If rural, give location)		1706 1/2 McCulloh Street 21217	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Female		Negro		Widowed		1-10-1889	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Domestic		Private Family		Maryland (Baltimore)		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Fred Johnson				Susie Jackson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				219-30-8235		RECORDS: BCH 4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		4 days	
				(B) DUE TO		Chronic renal disease unknown	
				(C) DUE TO		Arteriosclerotic cardiovascular disease unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from 6-1-19 67 to 6-25-19 67, that (I) ( <del>we</del> ) last saw the deceased alive on 6-24-19 67 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.				23A. SIGNATURE		23B. DATE SIGNED	
				R. Tarsy		JUNE 25, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Daniel Tarsy				Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/28/67		Mount Auburn Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUN 27 1967		Robert E. Taylor		Herbert E. Nutter 3035 W. North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

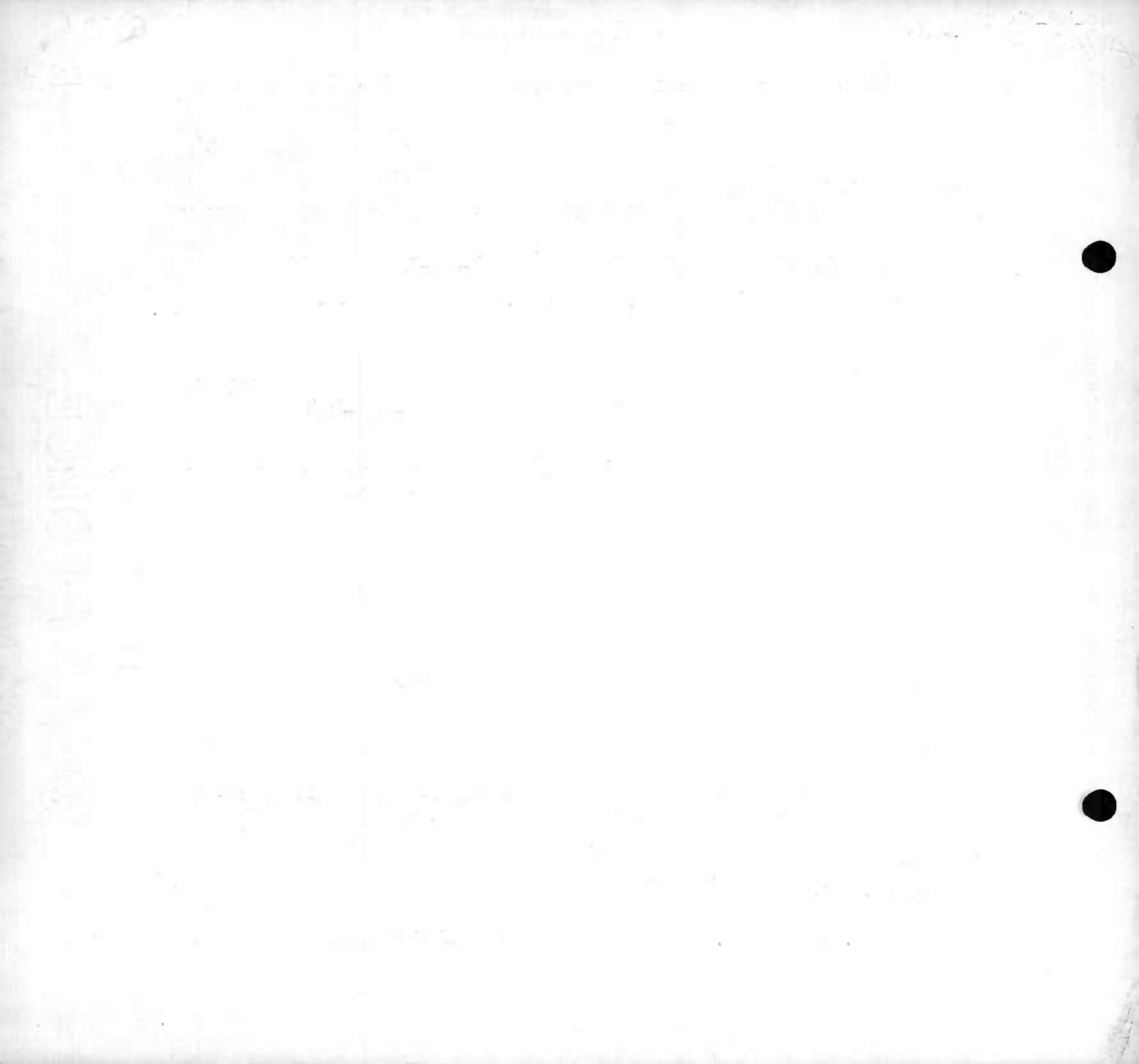
BIRTH NO. 67 6188				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6188	
1. NAME OF DECEASED (Type or Print) <b>Mary E. Fenwick</b>				2. DATE AND HOUR OF DEATH <b>June 23, 1967 1:40 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bar Wil Ba Convalescent Home 2101 W. Cold Spring Lane</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 53-00</b> D. STREET ADDRESS (If rural, give location) <b>6106 Clarks Lane - Mt. Washington</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 18, 1867</b>	9. AGE (In years last birthday) <b>100 Yrs.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>		11. BIRTHPLACE (State or foreign country) <b>Saint Mary's Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Dotson</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Thomas</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Josephine Fenwick-6106 Clarks Lane</b>			
18. <b>4431</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive arteriosclerotic C.V.D. Old age</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO (B) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5-4-1963</b> to <b>6-23-67</b> 1967, that (I) (we) last saw the deceased alive on <b>6-20-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C.R. Campbell</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6-26-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>C.R. Campbell</b>				23D. ADDRESS M.D. <b>1618 W. North Ave. Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/27/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <b>E. J. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter-3035 W. North Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-48-64-1B A 48-64-1B		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6189	
67 6189		CERTIFICATE OF DEATH			
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>ROBERT LEE ALLMOND</b>		2. DATE AND HOUR OF DEATH <b>24 JUNE 1967 10 55 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balti</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE CITY HOSPITALS</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>107 EGGES LANE #21228</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>4-11-12</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yard Man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>John S. Wilson Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Greenville S.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Allmond</b>			
14. MOTHER'S MAIDEN NAME <b>Eva Brown</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>251-09-1973</b>			
16. SOCIAL SECURITY NO. <b>251-09-1973</b>		17. INFORMANT <b>#21224</b>		ADDRESS <b>RECORDS-BCH-4940 EASTERN AVENUE</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>199.21</b>		CAUSE OF DEATH (A) <b>CARCINOMA FLOOR OF MOUTH AND NECK</b> (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>13 JUNE 1967</b> to <b>24 JUNE 1967</b> , that (I) (we) last saw the deceased alive on <b>24 JUNE 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Daniel D. Foote</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>24 JUNE, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. DANIEL D. FOOTE</b>		23D. ADDRESS <b>#21224 BCH-4940 EASTERN AVENUE-BALTIMORE, MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/29/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Western Star Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Catonsville Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltz</b>		25C. FUNERAL DIRECTOR <b>Nutter Funeral Home -3035 W. North Ave.</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6190</u>	
BIRTH NO. <u>67 6190</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MARY H. CLASSON</u>		2. DATE AND HOUR OF DEATH <u>June 25, 1967.</u> <u>4.02 p.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Century Nursing Home</u> <u>102 N. Paca St.</u>		A. STATE <u>Md.</u> B. COUNTY <u>Balto</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>10 Chesley Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 23, 1874.</u>	9. AGE (In years lost birthday) <u>92</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas Healy</u>			14. MOTHER'S MAIDEN NAME <u>Eleanor Steever</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-8799D</u>		17. INFORMANT ADDRESS <u>Mr. Earle Vavrina, 28 W. Elm Ave. #6</u>	
18. <u>422.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cardio Respiratory Failure</u> <u>Congestive Heart Failure</u> <u>Art. C.V. HD</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Gen. Arteriosclerosis</u> <u>Senility</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 29 1965</u> to <u>June 25 1967</u> , that (I) (we) last saw the deceased alive on <u>June 25 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William D. Appleford</u>				23B. DATE SIGNED <u>6/26/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>William D. Appleford</u>		23D. ADDRESS <u>5501 Park Heights Dr</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/28/67.</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 27 1967</u>		25B. NAME OF REGISTRAR <u>Wm. D. Appleford</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 6191		67 6191	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
FULTON S. BOZMAN			June 25, 1967 8:30 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
House in the Pines Nursing Home (Bel Aire) 5837 Belair Road, Balto.			Maryland Baltimore		
5. SEX			6. DATE OF BIRTH		7. AGE (In years lost birthday)
male			March 10, 1895.		72
6. RACE			8. BIRTHPLACE (State or foreign country)		9. CITIZEN OF WHAT COUNTRY?
white			Maryland		USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Retired Carpenter					Maryland
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John W. Bozman			Elizabeth Smith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					Mrs. Cecie McDaniel (Same)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I			Carcinomatous		—
ANTECEDENT CAUSES			DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			B		1 yr.
II			C		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/22 19 67 to 6/25 19 67, that (I) (we) last saw the deceased alive on 6/24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Albert B. Bradley				6/26/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Albert B. Bradley				4900 Belair Rd., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/28/67.		Baltimore Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 27 1967		E. J. Bradley		Leonard J. Ruck, Inc.-Balto., Md....14	

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Carrollton  
Duffy Lane

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Mr. B. B. B.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>67 6192</u>
BIRTH NO. <u>67 6192</u>		<b>CERTIFICATE OF DEATH</b>				
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mr. HAUPTMAN, JOHN EDWARD</u>		2. DATE AND HOUR OF DEATH <u>6/25/67</u> <u>12</u> <u>P</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u> B. COUNTY		
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 21214</u>		D. STREET ADDRESS (If rural, give location) <u>3205 MONTEBELLO TERRACE</u>		
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>04-20-1893</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>civilian empl. for U.S. Navy</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>John Hauptman</u>		14. MOTHER'S MAIDEN NAME <u>Katherine <del>xxxxxx</del> Wegferth</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No, unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW 1</u>		16. SOCIAL SECURITY NO. <u>220-44-7236</u>		17. INFORMANT <u>Mrs Edna Hauptman wife</u>		
18. <u>290.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Edema</u>		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Dr. Renick notified.</u>		(B) DUE TO <u>Megaloblastic Anemia (Clinical diagnosis)</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Azotemia (clinical diagnosis)</u>		(C) <u>The new man</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>jun 22 1967</u> to <u>jun 25 1967</u> , that <del>we</del> (we) lost saw the deceased alive on <u>jun 25 2pm 1967</u> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>We</del> (We) (did) ( <del>not</del> ) view the body after death.						
23A. SIGNATURE <u>Giselle T Bretz</u>				23B. DATE SIGNED <u>jun 25/67</u>		
23C. PHYSICIAN'S NAME (Type or Print) <u>Giselle T Bretz</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u> <u>Union Memorial Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/29/67.</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 27 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		
25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25D. ADDRESS				



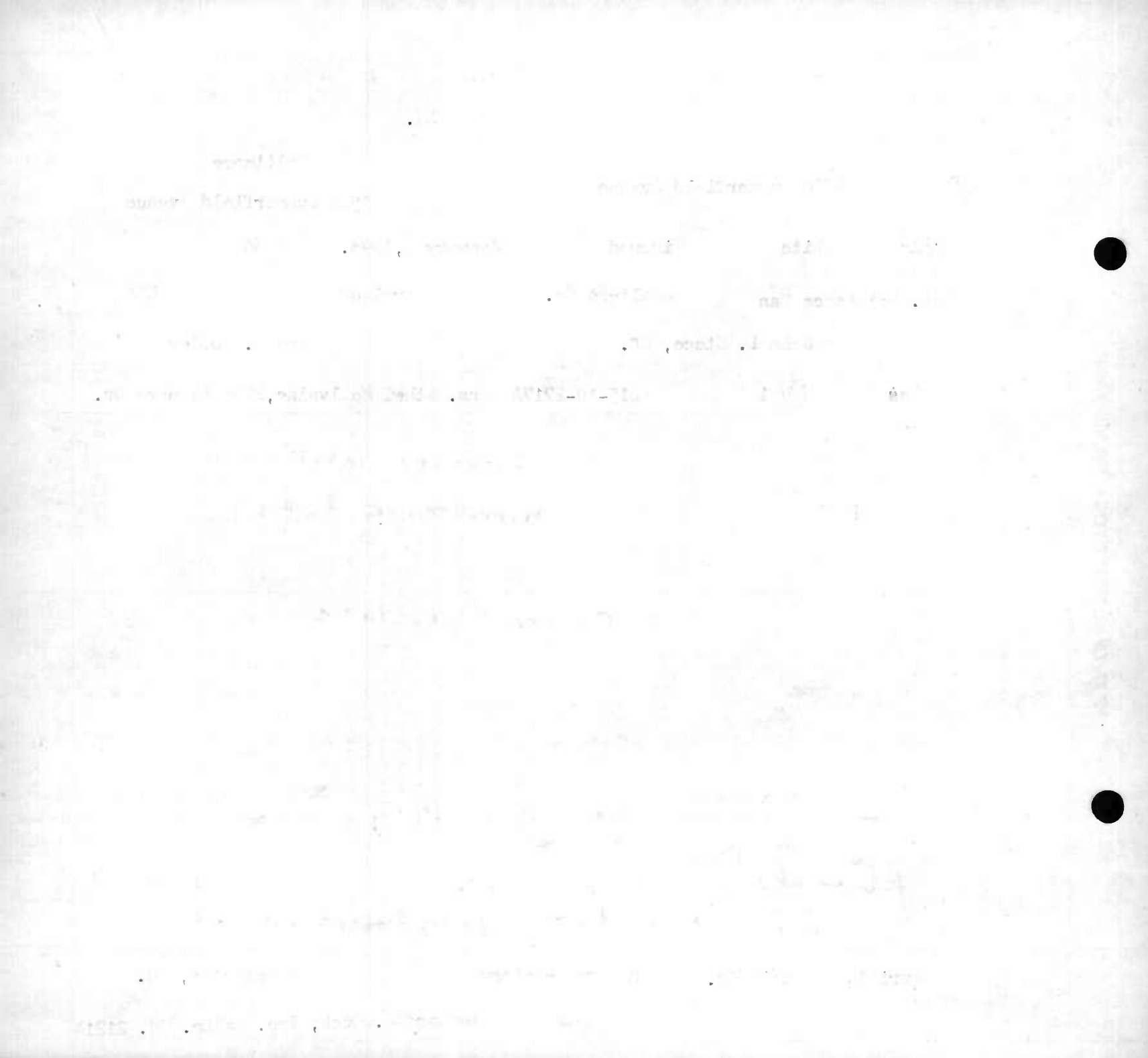
THE WHITE PAPER

THE WHITE PAPER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <b>67 6193</b>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <b>67 6193</b></span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>											
<div style="display: flex;"> <div style="flex: 1;"> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Howard Edward Stone</b> </div> <div style="flex: 1;"> <b>2. DATE AND HOUR OF DEATH</b> <b>6-26-67</b> <b>3 A.</b> M.                 </div> </div>											
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5520 Summerfield Avenue</b>						<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____  <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>Baltimore</b>  <b>D. STREET ADDRESS</b> (If rural, give location) <b>5520 Summerfield Avenue</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. RACE</b> <b>White</b>		<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>Widowed</b>		<b>8. DATE OF BIRTH</b> <b>January 5, 1898.</b>		<b>9. AGE</b> (In years lost birthday) <b>69</b>		<b>10. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Ret. Maintenance Man</b>				<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Sealtest Co.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>John L. Stone, Sr.</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary E. Eppler</b>					
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 1</b>				<b>16. SOCIAL SECURITY NO.</b> <b>215-10-2717A</b>		<b>17. INFORMANT ADDRESS</b> <b>Mrs. Ethel McIlvaine, 2708 Kildare Dr.</b>					
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Coronary insufficiency</b> DUE TO _____ (B) <b>Hypertensive heart disease</b> DUE TO <b>10 years</b> (C) _____ <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 yr.</b>											
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> <b>Cancer prostate</b>											
<b>19A. DATE OF OPERATION</b> <b>0</b>				<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>				<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)					
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)				<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>					
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>1950</b> <b>to</b> <b>June 26, 1967</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Mar. 7, 1967</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>											
<b>23A. SIGNATURE</b> <b>Ronald Jandorf</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>								<b>23B. DATE SIGNED</b> <b>6-26-67</b>			
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>R Donald Jandorf</b> M.D.						<b>23D. ADDRESS</b> <b>6077 Harford Rd</b>					
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>6/29/67.</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Kriders Cemetery</b>				<b>24D. LOCATION</b> (City, town, or county) (State) <b>Westminster, Md.</b>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JUN 27 1967</b>				<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Farley</b>				<b>25C. FUNERAL DIRECTOR ADDRESS</b> <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>720</b>
BIRTH NO. <b>67 6194</b>		<b>CERTIFICATE OF DEATH</b>		<b>67 6194</b>
M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>Mabel A. Shook (Needer)</b>		2. DATE AND HOUR OF DEATH <b>June 26, 1967 10:00 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bolton Hill Nursing Home</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21214</b> D. STREET ADDRESS (If rural, give location) <b>5208 Tramore St.</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>1898 February 28,</b>	9. AGE (In years last birthday) <b>69</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Companion</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
13. FATHER'S NAME <b>Edward J. Fitzpatrick</b>		14. MOTHER'S MAIDEN NAME <b>Mabel Coffin</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Patricia Everhart</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>180X I</b> <b>Carcinoma of left kidney</b> <b>Inability to move left leg</b> <b>Anemia (secondary)</b> <b>Collapsed T9 vertebrae</b>		INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date _____ and hour _____ and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>E. Ellsworth Cook</i> M.D.				23B. DATE SIGNED <b>6/26/67.</b>
23C. PHYSICIAN'S NAME (Type) <b>E. Ellsworth Cook</b>		23D. ADDRESS <b>2431 Maryland Avenue</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/29/67.</b>	24C. NAME of CEMETERY or CREMATORY <b>Immanuel Lutheran Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <b>22-58, Fe...</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	

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BIRTH NO. 67 6195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6195

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RACHEL

WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

June 24, 1967

3:42 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2924 W. North Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2924 W. North Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept 13, 1937

9. AGE (In years  
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore City S.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Henry Johnson

14. MOTHER'S MAIDEN NAME

Mattie Nile

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) If yes, give war or dates of service

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mattie Nile

ADDRESS

18. E981X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple Gunshot Wounds  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

2924 W. North Avenue

21D. TIME  
OF INJURY  
(APPROX.)

June 24, '67 3:42 a. m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot by husband

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/24/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal June 28/67

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

Monks Corner S.C.

24A. DATE REC'D BY HEALTH DEPT.

JUN 26 1967 Robert E. Taylor

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

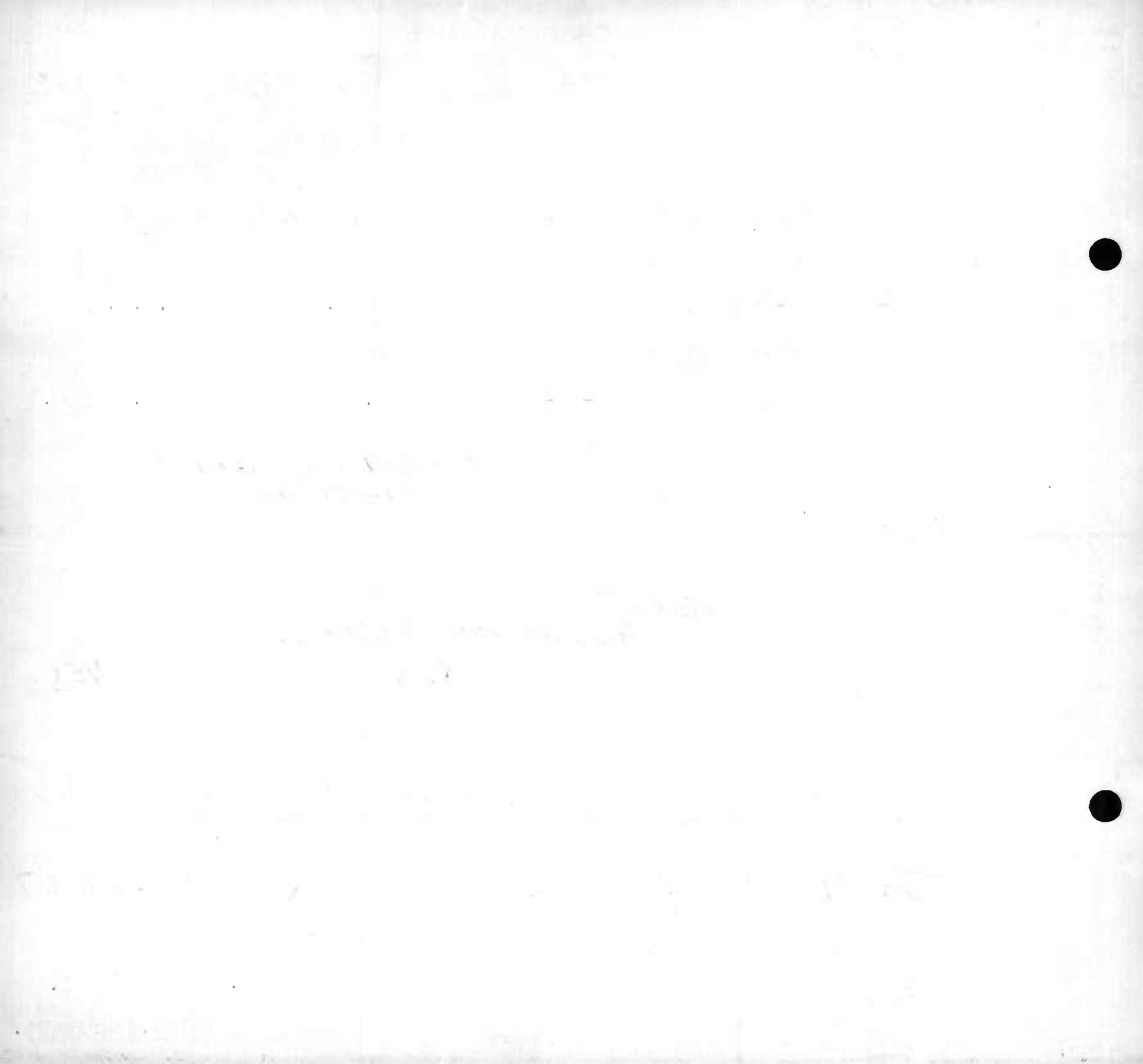
Milton E. Clicker 1129 N. Charles



**FUNERAL DIRECTOR: IMPORTANT**

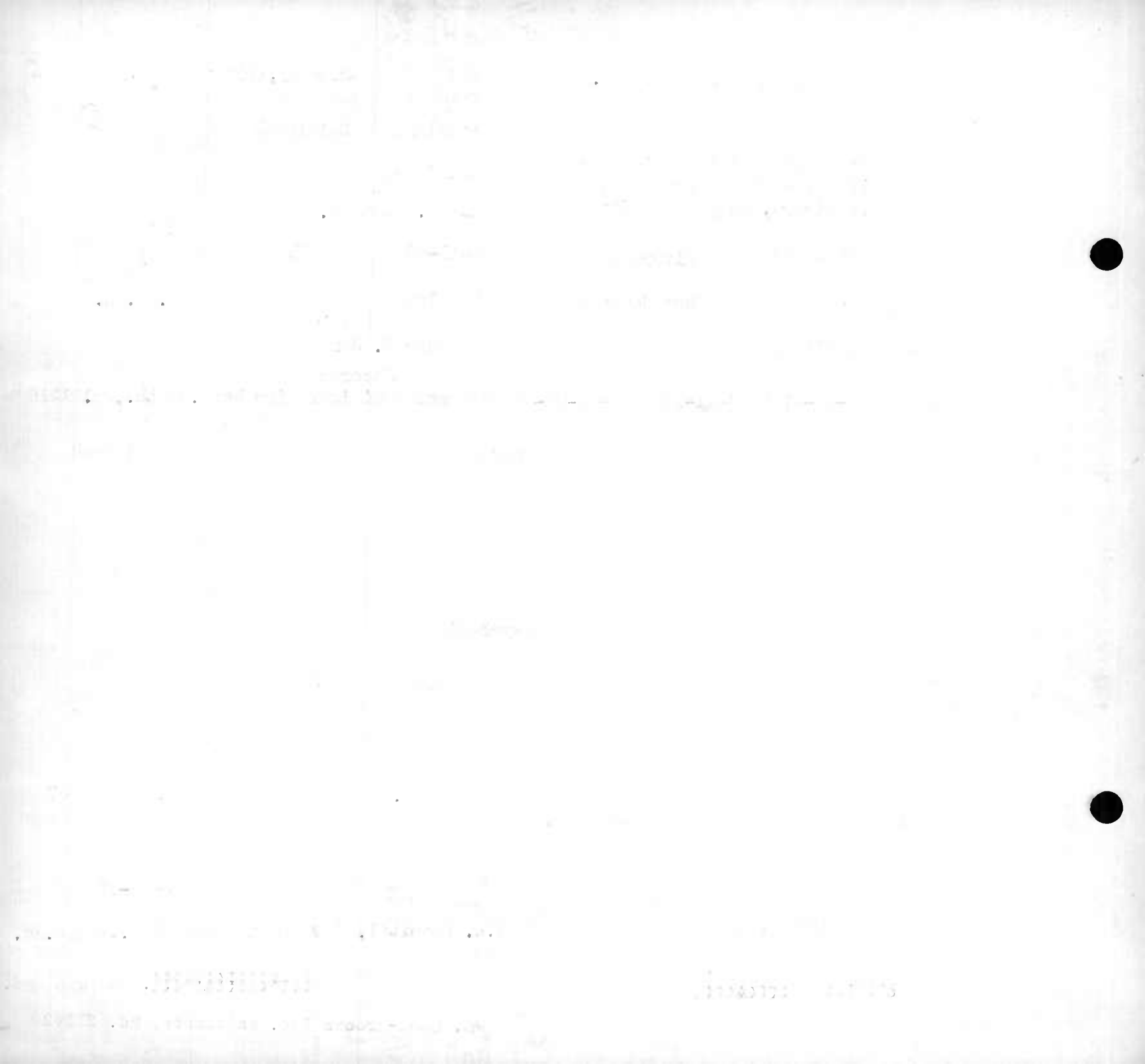
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6196		<b>CERTIFICATE OF DEATH</b>		Registered No. 67 6196	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)		
			Grace Herb.		
2. DATE AND HOUR OF DEATH			6/25/67 8:35 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
43 South Baltimore General Hosp.			Maryland 7-02		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			Baltimore #21205		
D. STREET ADDRESS (If rural, give location)			610 N. Luzerne		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F.	White	Widow	4/9/91	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk-Gordons-Retired		None		Baltimore Md.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
James Henry Coleman			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no none			220-05-1302		2122 6
18. 4-65X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
			(A) PULMONARY EMBOLIZATION BILATERAL		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II RECENT			ABDOMINAL ABSCESS		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2					YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (this hospital) attended the deceased from 6-25 19 67 to 6-25 19 67, that (we) lost saw the deceased alive on 6-25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED
Dr. M. Kaufman					6-26-67
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. M. Kaufman			1213 Light St.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	6/28/67	Parkwood Cemetery		Taylor Ave. Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 27 1967		Robert E. Taylor		KRAUSE FUNERAL HOME 1216S. Charles St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6197</b>	
BIRTH NO. <b>67 6197</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>STARLINGS, Stanley W.</b>		2. DATE AND HOUR OF DEATH <b>June 23, 1967 5:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		D. STREET ADDRESS (If rural, give location) <b>610 E. 31st St.</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>4-11-96</b>	9. AGE (In years lost birthday) <b>71</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Shoe Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Frank Starlings</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor N. Jones</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3-19-17 to 3-11-19</b>		16. SOCIAL SECURITY NO. <b>216-03-09-83</b>		17. INFORMANT <b>Records</b> ADDRESS <b>Veterans Administration Hosp. Balto., Md. 21218</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Pneumonia</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Psychosis</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Yes</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 21, 1967</b> to <b>June 23, 1967</b> , that <b>XX</b> (we) last saw the deceased alive on <b>June 23, 1967</b> and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>XX</b> (We) (did) ( <del>XXXX</del> ) view the body after death.					
23A. SIGNATURE <b>Allan Johnson</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-23-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Allan Johnson</b>		23D. ADDRESS M.D. <b>V.A. Hospital, 3900 Loch Raven Blvd., Balto. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/26/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>	
24D. LOCATION <b>Woodlawn, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</b>			

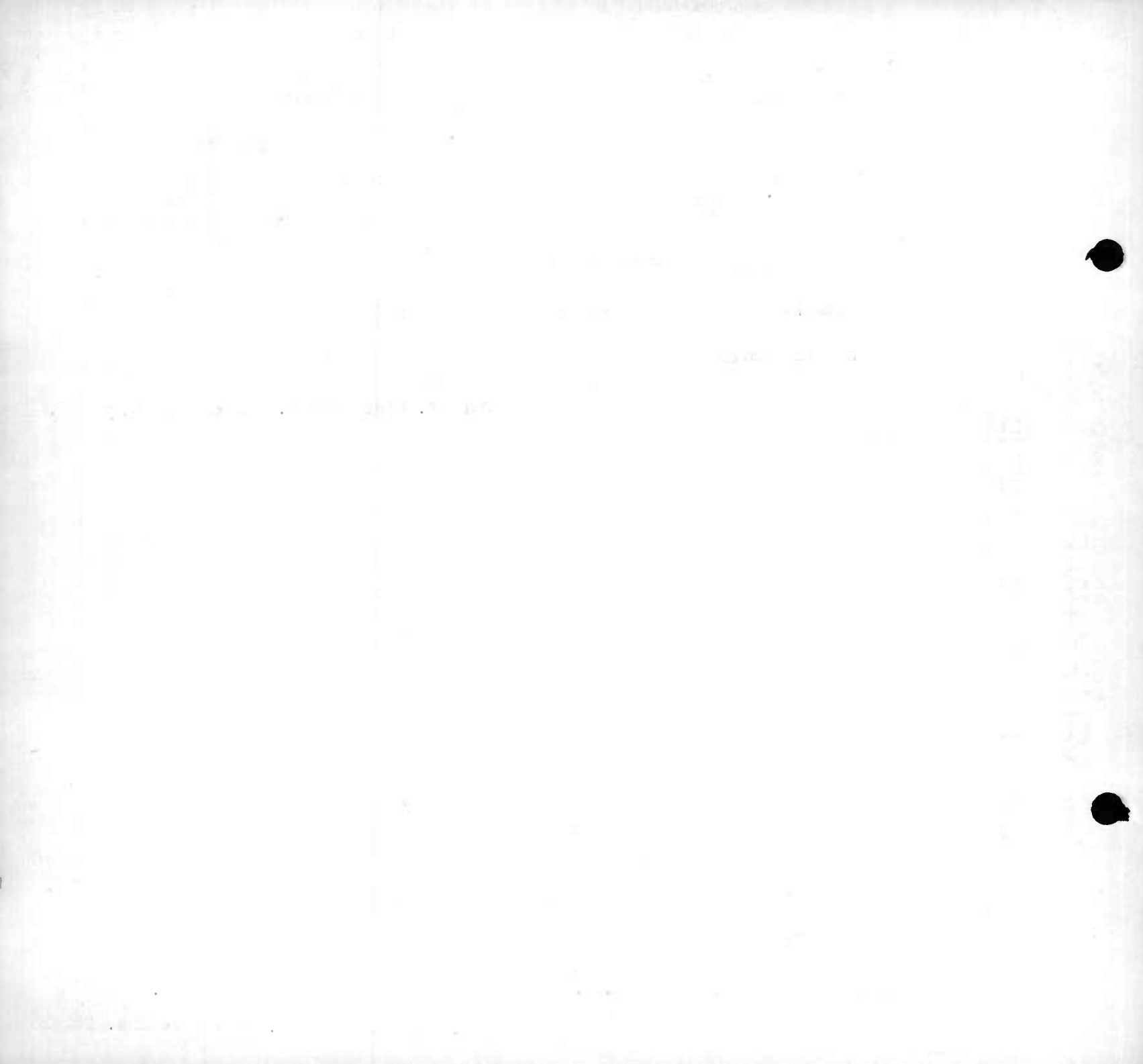




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

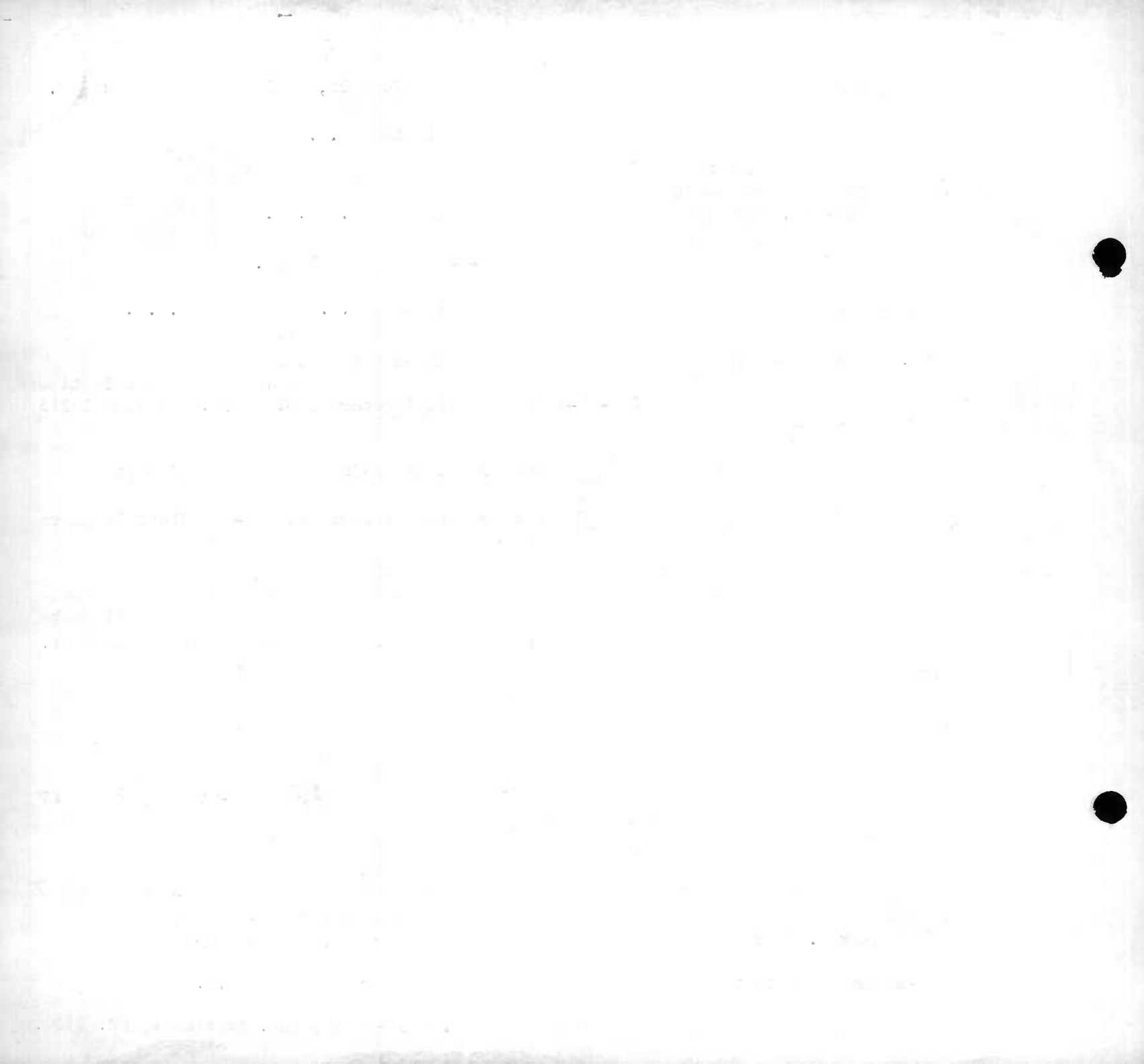
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6198</b>	
BIRTH NO. <b>67 6198</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>HOOPER, MABEL L.</b>		2. DATE AND HOUR OF DEATH <b>6/23/67 12 NOON</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 HOUSE IN THE PINES BELVEDERE Nursing Home</b>		A. STATE <b>Md.</b> B. COUNTY <b>9-07</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>1771 Homestead St</b>			
5. SEX <b>F</b>	6. RACE <b>CAU.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never Married</b>		8. DATE OF BIRTH <b>3/8/89</b>	9. AGE (In years last birthday) <b>78</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charles Hoover</b>		14. MOTHER'S MAIDEN NAME <b>Ida ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>John F. Clark 319 E. University Pkwy</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>4221 I</b>		CAUSE OF DEATH (A) <b>Intermittent CV Disease</b> (B) (C) INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/17/67</b> 19 <b>67</b> to <b>6/23/67</b> 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>6/20</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald Wilson</b>				23B. DATE SIGNED <b>6/23/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. D. WILSON</b>				23D. ADDRESS <b>M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/26/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. John's Church</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Md</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6199				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6199	
1. NAME OF DECEASED (Type or Print) <b>Hester Campion</b>				2. DATE AND HOUR OF DEATH <b>June 23, 1967 7:28 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Seton Psychiatric Institute 6420 Reisterstown Road Baltimore, Maryland 21215</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Washington, D.C.</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>V-48</b> D. STREET ADDRESS (If rural, give location) <b>1115 Eye St., N. W.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>4-9-94</b>	9. AGE (In years last birthday) <b>73 yrs.</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Jesse Lewis Heiskell</b>			14. MOTHER'S MAIDEN NAME <b>Edith Augusta Vickery</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>204-01-8947</b>	17. INFORMANT ADDRESS <b>Seton Psychiatric Institute Hospital Records, Baltimore, Maryland 21215</b>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral thrombosis</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebral and general arterio-sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>About 10 years</b> <b>31 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Schizophrenic reaction, chronic undifferentiated type.</b>							
19A. DATE OF OPERATION <b>June 23, 1967</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>December 21, 1938</b> to <b>June 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 23, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Walter O. Jahrreiss</b>				M.D. Attending Phys. <input type="checkbox"/> for Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>June 24, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Walter O. Jahrreiss</b>		23D. ADDRESS <b>Seton Psychiatric Institute Baltimore, Maryland 21215</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>6/24/67</b>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</b>			



1  
C-516

67 6200

BALTIMORE CITY HEALTH DEPARTMENT

67 6200

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)AMERCIUS J. CIANFERANO ~~XXXXXXXXXX~~

2. DATE AND HOUR PRONOUNCED DEAD

June 23, 1967 9:57 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED  
FULL NAME OF (If not in hospital or institution, give street  
HOSPITAL OR ADDRESS OR LOCATION)  
INSTITUTION 6-28-674. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

720 W. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

AUG. 29, 1915

9. AGE (In years  
last birthday)

56 5 2

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Driver

10B. KIND OF BUSINESS OR INDUSTRY

Ice Co.

11. BIRTHPLACE (State or foreign country)

Balto, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alfredo Cianferano

14. MOTHER'S MAIDEN NAME

Mildred Jannarilli

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. 11

16. SOCIAL  
SECURITY NO.

214-03-0396

17. INFORMANT

ADDRESS

Miss Mary Cianferano, 433 W. 23rd St.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

xxxxxx Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/24/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/27/67

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION (City, town, or county)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 27 1967

24B. NAME OF REGISTRAR

Robert E. J. J. J.

24C. FUNERAL DIRECTOR

ADDRESS

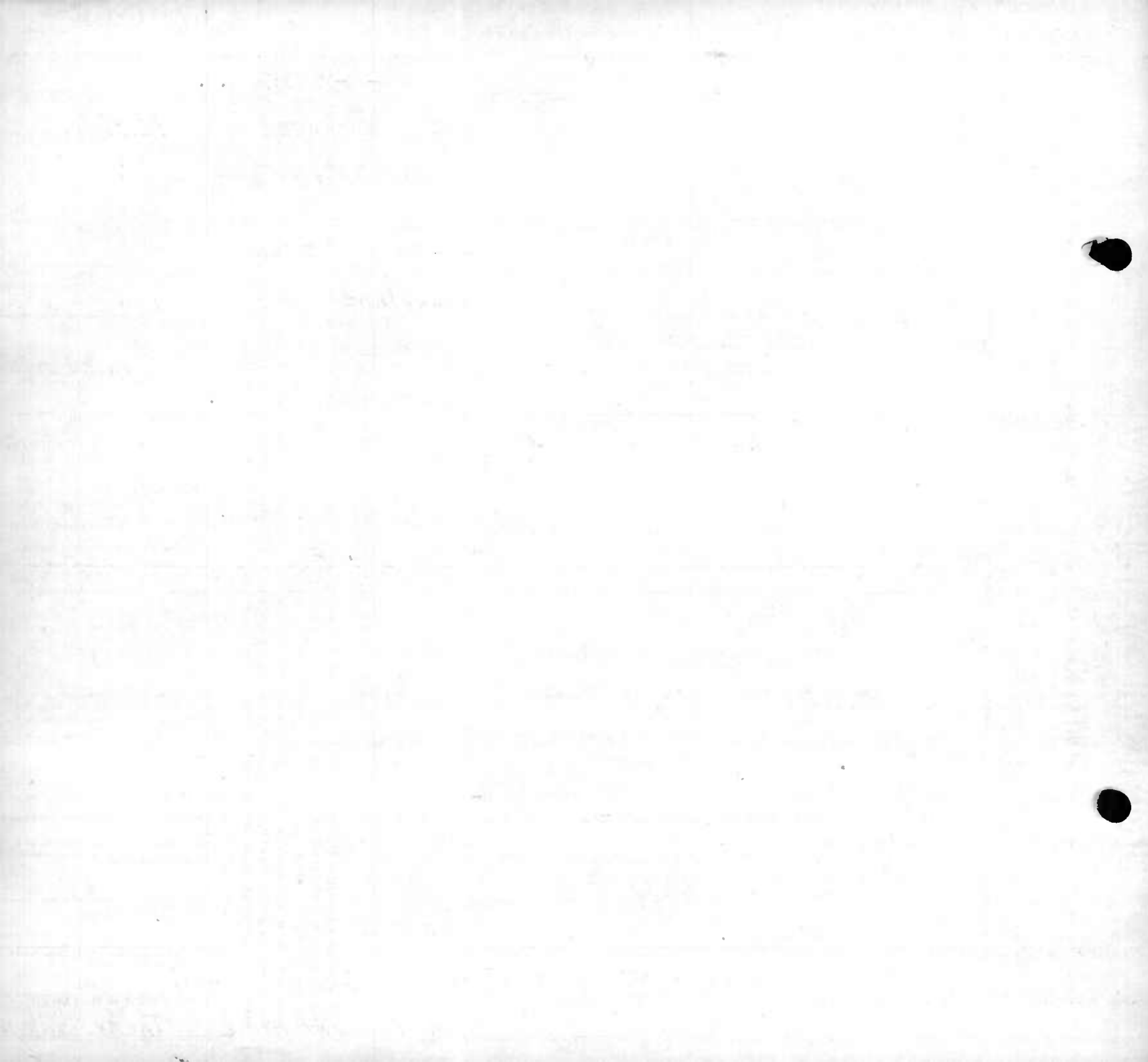
Wm. Cook-Brooks Inc. 1217 St. Paul St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-12029 67 6201</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 6201</u>	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
<u>GARRISON, BABY BOY</u>			<u>6-23-67 3:30 A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME &amp; HOSPITAL</u>			A. STATE <u>BALTIMORE</u>		
(If not in hospital or institution, give street address or location)			B. COUNTY <u>BALTIMORE</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 22, MARYLAND</u>		
			D. STREET ADDRESS (If rural, give location) <u>3400 OLD NORTH POINT ROAD</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>6-21-67</u>	9. AGE (In years lost birthday) <u>2 days</u>	If Under 1 Yr. Months: <u>2</u> Days: <u>2</u> If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>HERBERT GARRISON</u>			14. MOTHER'S MAIDEN NAME <u>LULA MORRISON</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>3400 OLD NORTH POINT RD.</u>		
18. <u>761.5T</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>prematurity + prematurity</u> <u>membranes + heavy vaginal bleeding - atypical placenta</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-21-67</u> 19 <u>67</u> to <u>6-23-67</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-23</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louder T. Saradpon</u>				23B. DATE SIGNED <u>6-23-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>LOURDES T. SARADPON</u>				23D. ADDRESS <u>CHURCH HOME &amp; HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-25-67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>WYATT MT. Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Greene County VA.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 27 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>RYAN FUNERAL HOME STANARDSVILLE</u>			





1  
D-240

67 6202

BALTIMORE CITY HEALTH DEPARTMENT

67 6202

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)  
ERNEST

2. DATE AND HOUR PRONOUNCED DEAD

June 24, 1967 12:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

700 Fleet Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

309 S. High Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

OCT. 10 1893

9. AGE (In years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

TAILOR

10B. KIND OF BUSINESS OR INDUSTRY

MENS CLOTHING

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF  
WHAT COUNTRY?

ITALY

13. FATHER'S NAME

ANTHONY DI GULIO

14. MOTHER'S MAIDEN NAME

?????

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

"217-67-0200

17. INFORMANT

ADDRESS

MRS. MARY DI GULIO 309 S. HIGH ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Drowning  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Harbor

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Pier #6 - East Falls Avenue

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour) (Minute)  
June 24, '67 12:15 P.M.

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subj. jumped or fell into harbor

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/25/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

JUNE 28th 1967 HOLY REDEEMER BALTO. Md.

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county) (State)

322 S HIGH ST

24A. DATE REC'D BY HEALTH DEPT.

JUN 27 1967

24B. NAME OF REGISTRAR

Robert E. Spitz

24C. FUNERAL DIRECTOR

Frank Della Torre 322 S High St

ADDRESS



Franklin D. Roosevelt 3222 11/11

BIRTH NO.		67 6203		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 67 6203	
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR PRONOUNCED DEAD				
OR MORRISON VIRGINIA LEE TRANSPARENTI					June 21, 1967 4:30 P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE Maryland				
1009 E. Lombard Street					C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 1009 E. Lombard Street, 3rd Floor				
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH MAY 28 1909		9. AGE (in years last birthday) 58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) KY.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME VERN ROBERTS					14. MOTHER'S MAIDEN NAME VADA RICE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT MR. JOSEPH TRANSPARENTI 1009 E LOMBARD ST			
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Epilepsy									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles S. Springate, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
					DATE SIGNED June 22, 1967				
23A. BURIAL CREMATION, REBURY (Specify) BURIAL		23B. DATE 6/24/67		23C. NAME OF CEMETERY OR CREMATORY GARDEN OF FAITH		23D. LOCATION (City, town, or county) (State) BALTO. Md.			
24A. DATE REC'D BY HEALTH DEPT. JUN 27 1967		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR Frank D. Dill		24D. ADDRESS 322 S HIGH ST			

WALTON

7

*Handwritten signature*

1  
E. 163

65-12485?

35/99

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 6204 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6204  
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>KENNETH EVERETT</b>			2. DATE AND HOUR PRONOUNCED DEAD <b>6-26-67 2:25 AM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME AND HOSPITAL - DOA</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2043 E. Lombard Street</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>2-24-19</b>	9. AGE (In years, lost birthday) <b>24</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

MEDICAL CERTIFICATION	18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hemoperitoneum - Laceration of liver</b> <del>XXXXX</del> and retroperitoneal hemorrhage <b>Blunt injury of abdomen</b>				INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
	19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
	21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2043 E. Lombard Street</b>		
	21D. TIME OF INJURY (APPROX.) <b>6 26 '67 2:00 AM</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Beaten by father</b>		
	22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <b>XX</b> ACTUAL SIGNATURE <b>RUSSELL S. FISHER, M.D.</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
	DATE SIGNED <b>6-26-67</b>				

23A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>	23B. DATE <b>6/28/67</b>	23C. NAME of CEMETERY or CREMATORY <b>Garden of Faith</b>	23D. LOCATION (City, town, or county) (State) <b>Balto - Md.</b>
24A. DATE REC'D BY HEALTH DEPT. <b>JUN 27 1967</b>	24B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	24C. FUNERAL DIRECTOR <b>Frank Delaplane</b>	ADDRESS <b>312 S. High St</b>

N 869.2

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6205				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6205	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Charles R. Gosnell		6-24-67 4:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Md.		B. COUNTY	
Church Bone & Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 7-02	
D. STREET ADDRESS (If rural, give location)				908 N. Port St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
Male	White	Married	4-20-97	70			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Guard		Church Bone and Hospital		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Gosnell				Louise -			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes WWI		213059418		Victoria M. Gosnell		5909 Arizona Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		Unknown	
ANTECEDENT CAUSES				(B) DUE TO		Unknown	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				Infected leg ulcer			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6-18 1967 to 6-24 1967, that (I) (we) last saw the deceased alive on 6-18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Rodelio M. Lim						6-24-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Rodelio M. Lim				Church Bone & Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/28/67		Baltimore National Cemetery		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 28 1967		Robert E. Talbot		Rufus E. Gwath		1211 Chasaco Ave.	

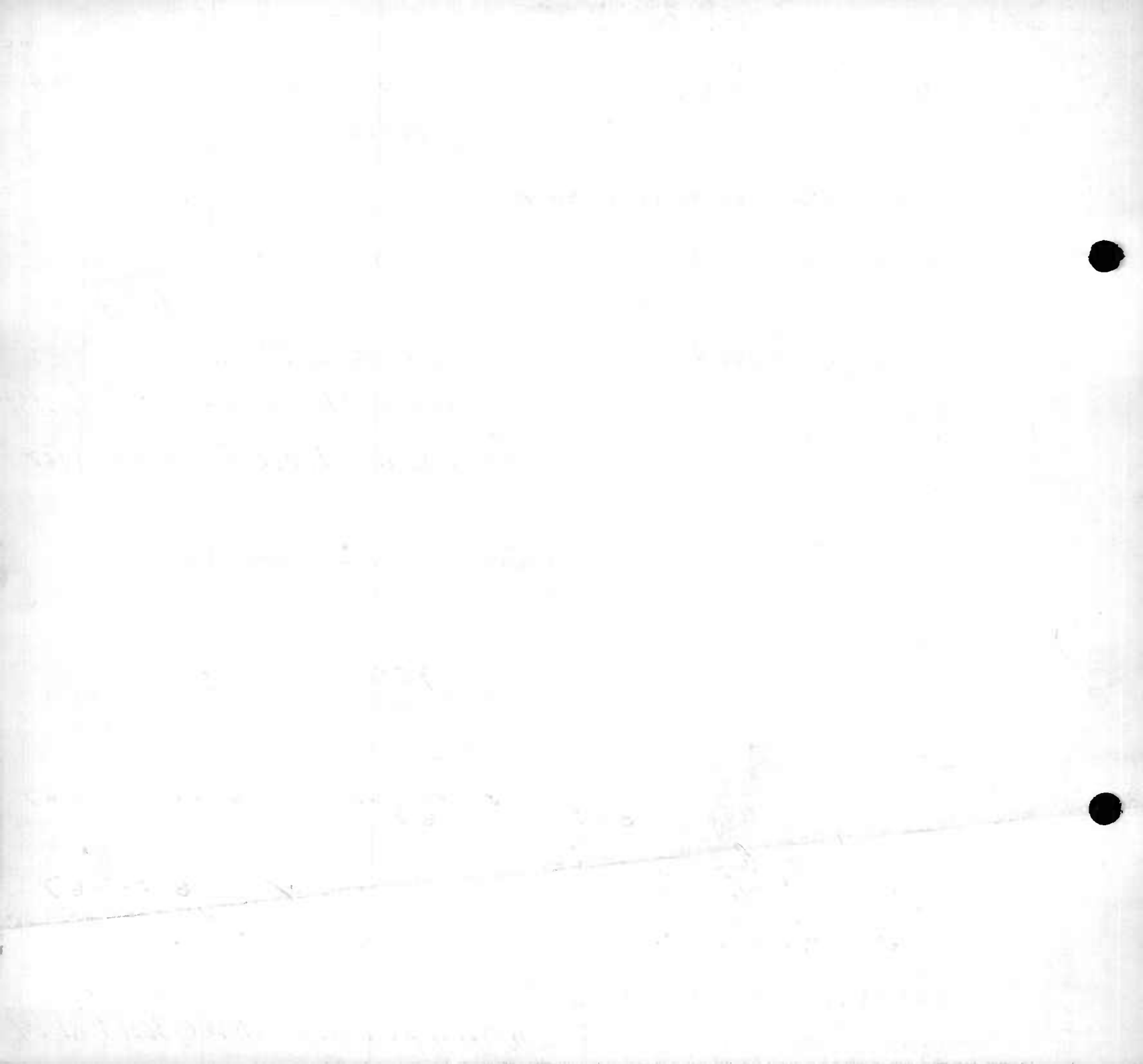




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

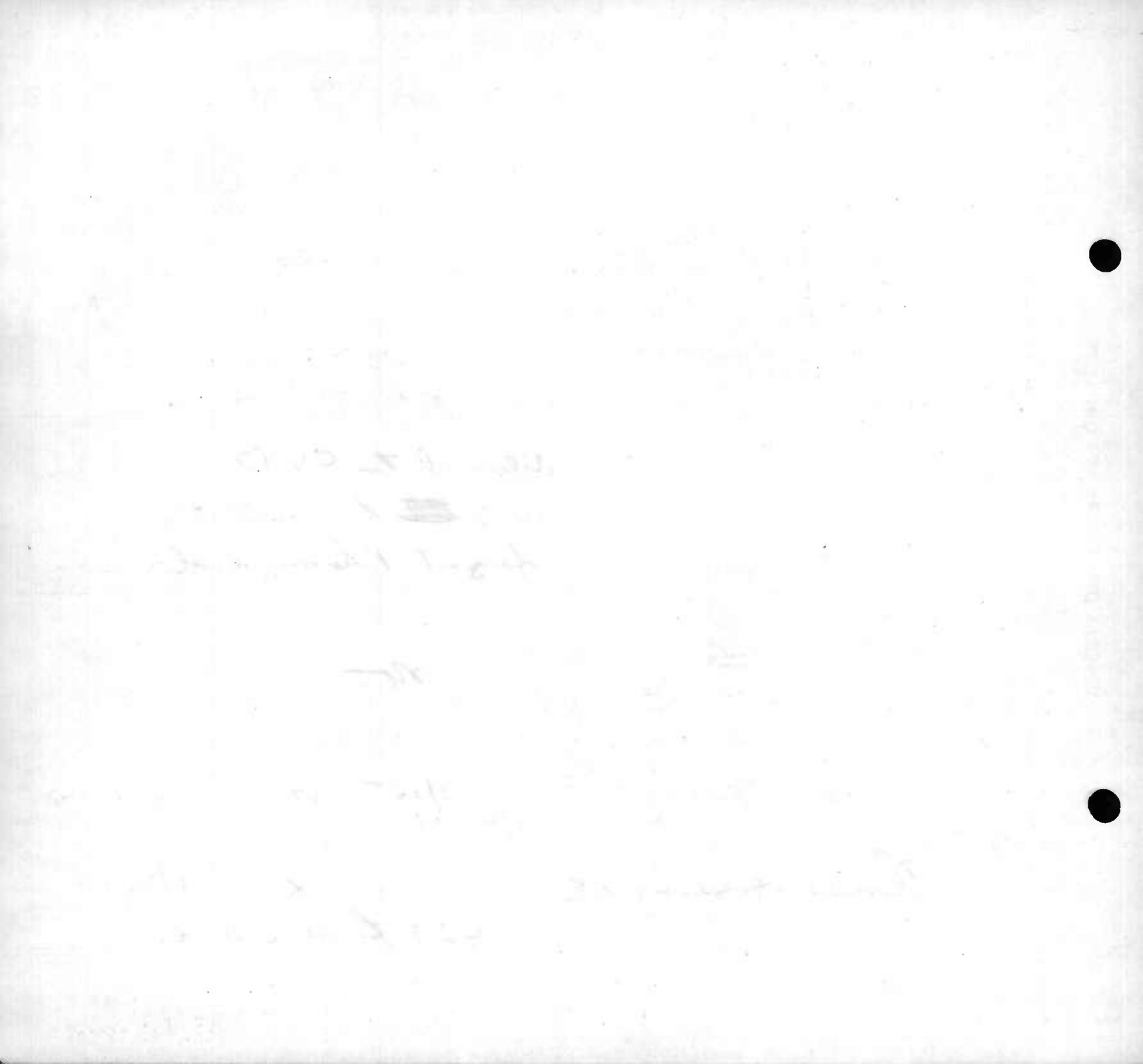
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67-6206</b>	
BIRTH NO. <b>67 6206</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Namie Shivery</b>		2. DATE AND HOUR OF DEATH <b>6-25-67 10:21 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>24-03</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore Gen. Hosp.</b>		D. STREET ADDRESS (If rural, give location) <b>1295 Williams St</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>Widowed</b>	8. DATE OF BIRTH <b>JAN 6-1888</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John W Shock</b>		14. MOTHER'S MAIDEN NAME <b>ELLA E Witcomb</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Harold W Shivery</b> ADDRESS <b>2431 N Calvert St</b>	
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Diabetes Mellitus</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <b>Atherosclerotic Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1940-1967</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>YES -</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-25-67</b> 19 to <b>6-25</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-25</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jose V. Iglesias</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-25-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jose V. Iglesias</b>		23D. ADDRESS <b>1213 Light St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 28 67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gowanus Presbyterian</b>	
24D. LOCATION (City, town, or county) (State) <b>York Rd Balto Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR <b>Burgess Funeral Home</b> ADDRESS <b>3631 Falls Rd</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 6207	
BIRTH NO. 67 6207		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>FRANK H. GREENWALT</b>		2. DATE AND HOUR OF DEATH <b>6-26-67</b>   <b>8:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b> (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO. #12</b> D. STREET ADDRESS (If rural, give location) <b>1219 COCHRAN AVE.</b>			
5. SEX <b>MALE</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>2-11-89</b>	9. AGE (In years last birthday) <b>78</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRUG DEPT.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NEIGHBORHOOD PHARMACY</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Thomas S. Greenwalt</b>			
14. MOTHER'S MAIDEN NAME <b>Smith, Alice C.</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>			
16. SOCIAL SECURITY NO. <b>019-03-8244</b>		17. INFORMANT ADDRESS <b>Patient 1219 Cochran Ave.</b>			
18. <b>4221 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Anterolateral CVD</b>		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>acute <del>thrombo</del> thromboembolism</b> (C) <b>suspect Pulmonary embolism</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/25</b> 19 <b>67</b> to <b>6/26</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/26</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald Redner MD</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/26/67</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. <b>827 Linden Ave.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/28/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Govans Presbyterian Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Seitz</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Eugenia K. Seitz 5209 York rd. Seitz Funeral Home Balto. Md. 21212</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

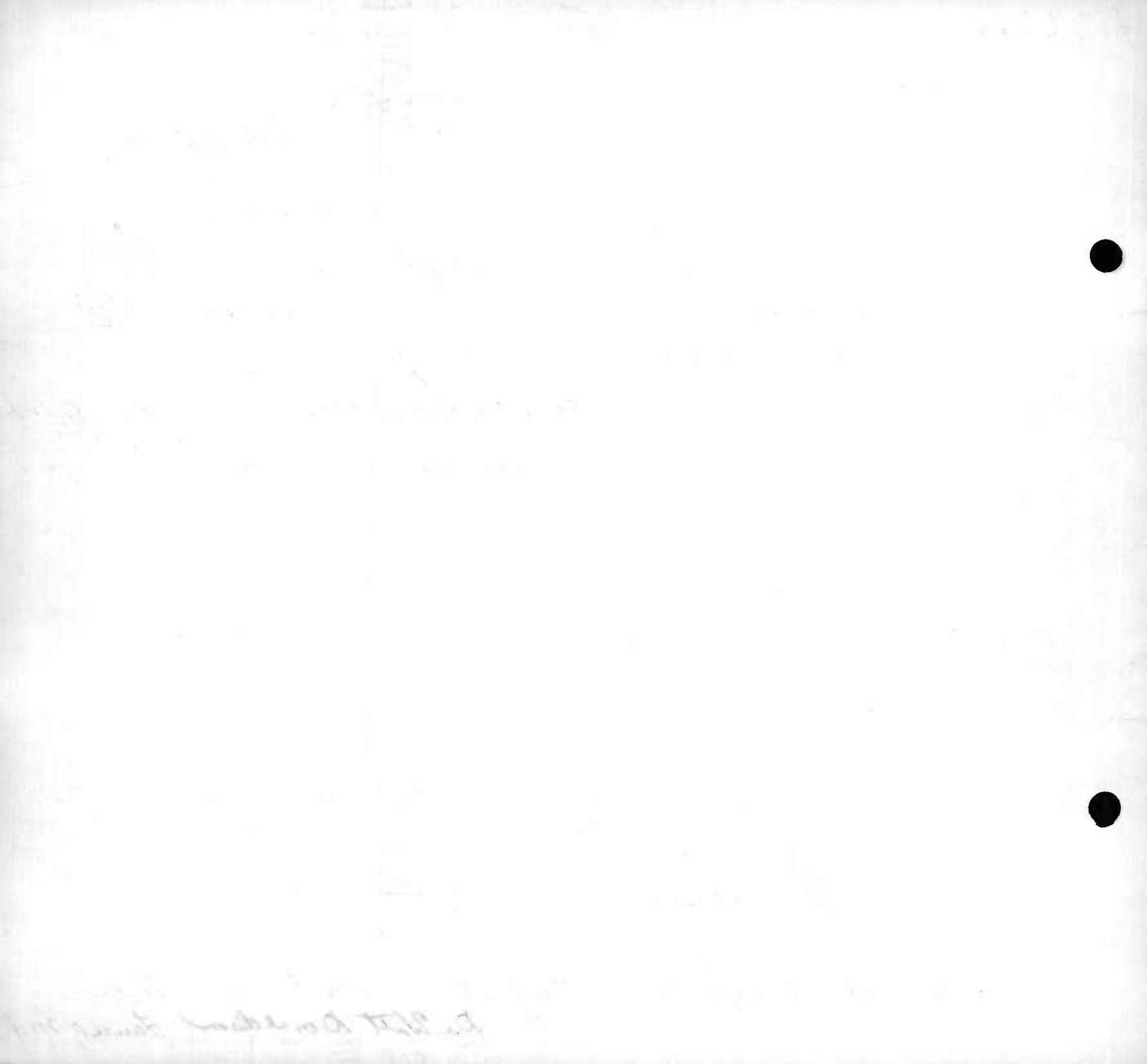
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6208</b>	
BIRTH NO. <b>67 6208</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Nicholas Lister</b>		2. DATE AND HOUR OF DEATH <b>June 26 1967   442 AM.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Gould Nursing Home 6116 Belair Road</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>26-10</b> D. STREET ADDRESS (If rural, give location) <b>110 S. Clinton Street</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>Nov-8-1893</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Eastern Shore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>James H. Lister</b>		14. MOTHER'S MAIDEN NAME <b>Anna Mahaley</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-03-0807-A</b>		17. INFORMANT <b>Leonard Lister</b> ADDRESS <b>110 S. Clinton Street</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>138.014-002.1</b> <b>Sarcoidosis (generalized)</b> <b>Arteriosclerotic C.V. disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Old Tuberculosis Complex</b>		CAUSE OF DEATH (A) <b>Sarcoidosis (generalized)</b> (B) <b>Arteriosclerotic C.V. disease</b> (C)		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 24, 1967</b> to <b>June 26 1967</b> , that (I) <del>was</del> lost saw the deceased alive on <b>June 25 1967</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was not</del> (did not) view the body after death.					
23A. SIGNATURE <b>H. V. Harbold</b> M.D.				23B. DATE SIGNED <b>June 27, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. V. HARBOLD</b>				23D. ADDRESS <b>4706 HARFORD Road Baltimore</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-29-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>		25C. FUNERAL DIRECTOR <b>Walter Dabrowski</b> ADDRESS <b>1005 Dundalk Avenue</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6208	
BIRTH NO. 67 6208		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type, or Print) <b>HABER ANTHONY JOSEPH</b>		2. DATE AND HOUR OF DEATH <b>6/23/67 12 30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>HABER</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Harward</b>			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL BALTIMORE, MD.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>JESSUP 63-00</b>			
		D. STREET ADDRESS (If rural, give location) <b>211 MISSION RD.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <b>8/17/76</b>	9. AGE (In years last birthday) <b>90</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STATIONARY ENGINEER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
13. FATHER'S NAME <b>FRANCIS H. HABER</b>		14. MOTHER'S MAIDEN NAME <b>LISETTE SCHMUTTE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-54-3755</b>		17. INFORMANT <b>Lawrence Crane-Jessup Md.</b>	
18. <b>493X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <del>HEART</del> <b>PNEUMONIA</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>PROSTATIC HYPERTROPHY + URINARY TR. INFECTION</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/18</b> 19 <b>67</b> to <b>6/23</b> 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>6/18</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. F. Seeger</b>				23B. DATE SIGNED <b>6/23/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. F. SEEGER</b>		23D. ADDRESS <b>U. HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/27/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR <b>DeWitt Donaldson Laurel Md</b>	

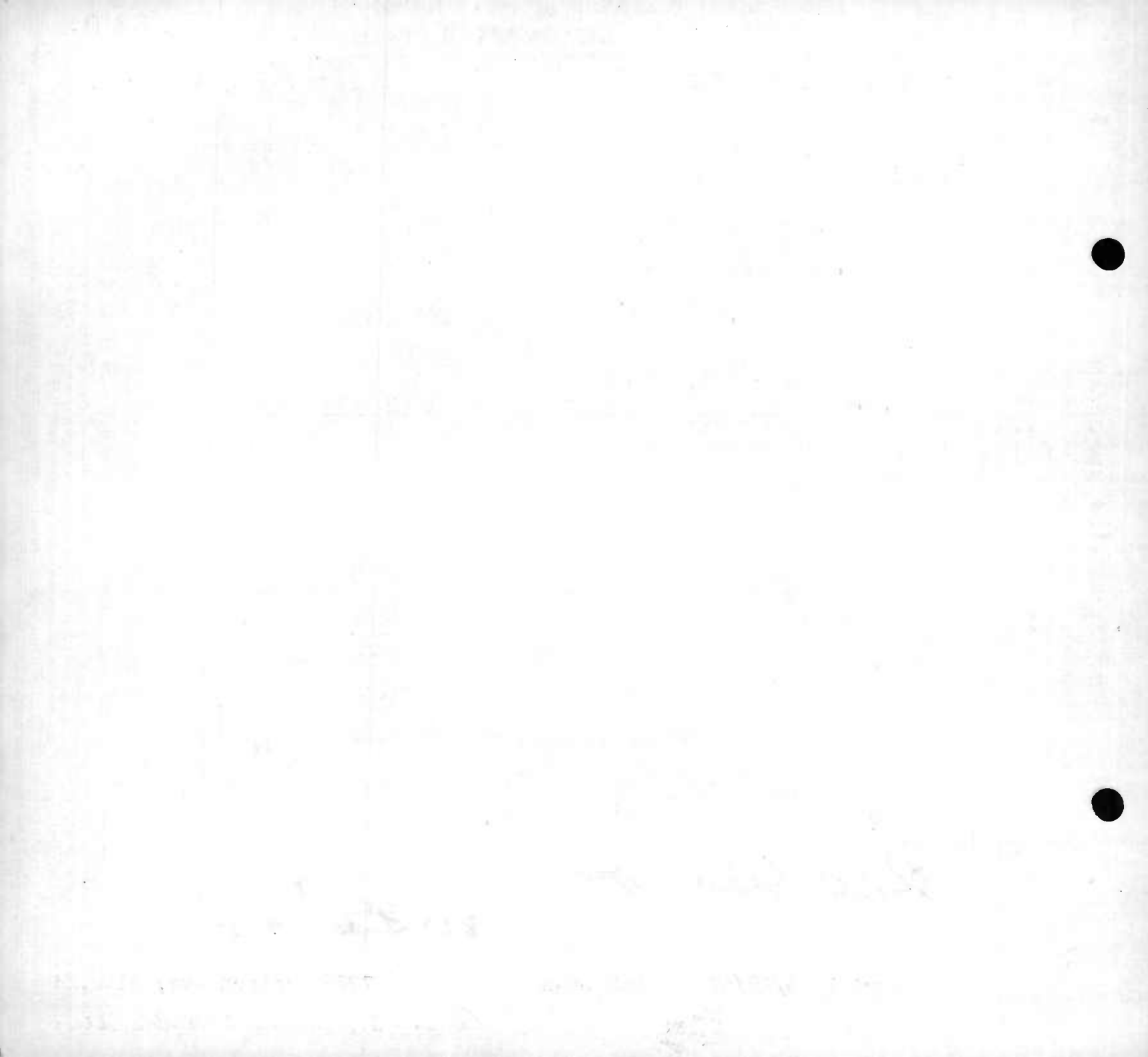




FUNERAL DIRECTOR: IMPORTANT

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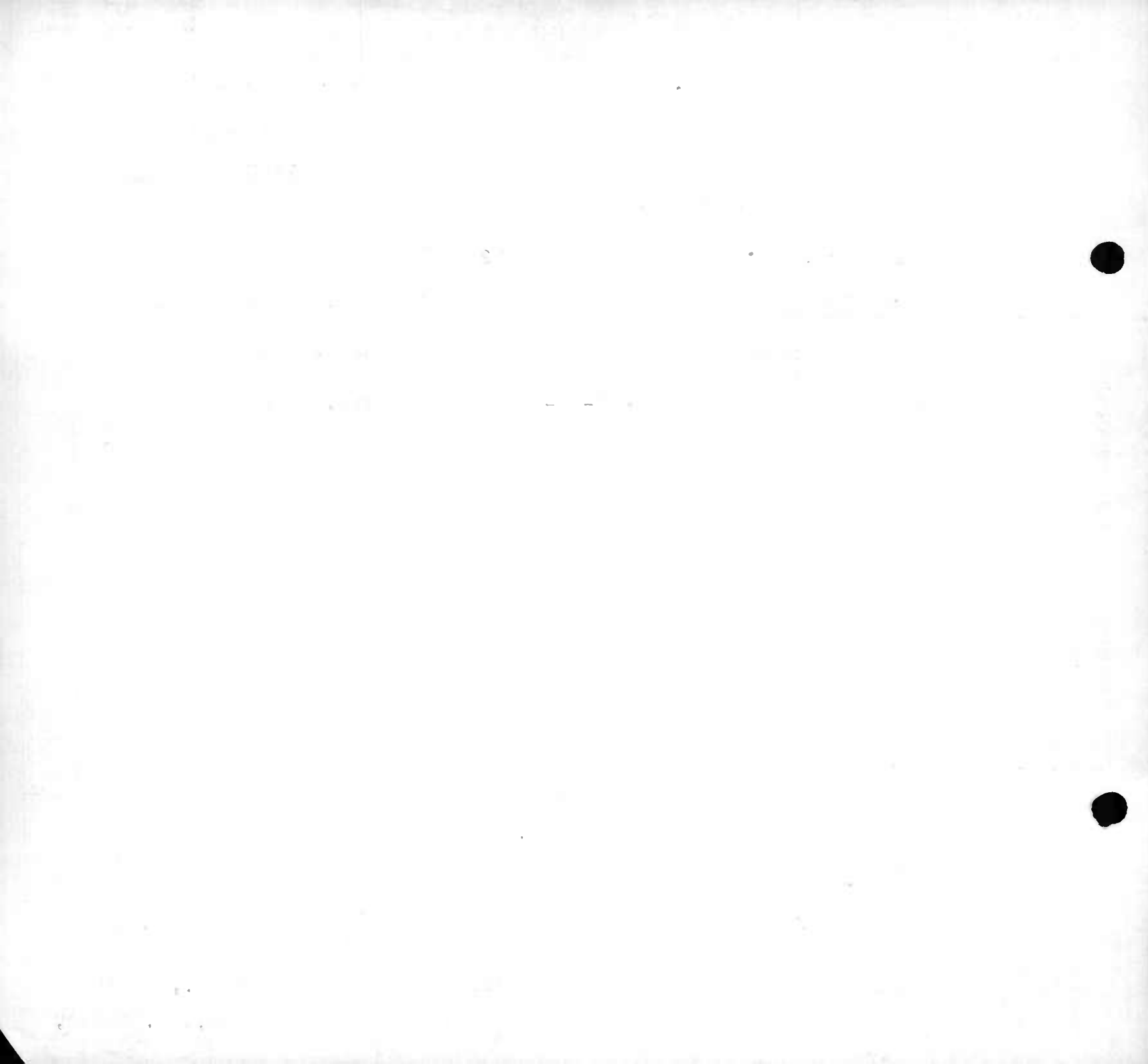
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6210</b>	
BIRTH NO. <b>67 6210</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>EARL I PUNTE</b>		2. DATE AND HOUR OF DEATH <b>6/26/67 3:10 AM 3.10 A. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b>		D. STREET ADDRESS (If rural, give location) <b>3742 ROLAND AVE</b>		<b>13-07</b>	
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1901 1102 NOV 10</b>	9. AGE (In years lost birthday) <b>65</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EARL PUNTI PAINTING PAINTING</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		13. FATHER'S NAME <b>CASPER PUNTE</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES NO</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>WIFE - GLADYS PUNTE - 3742 ROLAND AVE</b>	
18. <b>153.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>METASTATIC CARCINOMA TO LIVER</b> DUE TO (B) <b>ADENOMA OF COLON</b> DUE TO (C) <b>ADENOMA OF COLON</b>		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>6/10/67</b> 19 to <b>6/26/67</b> 19, that (I) (we) last saw the deceased alive on <b>6/26/67</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <i>Donald Feldner MD</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/26/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Donald Feldner</b>		23D. ADDRESS M.D. <b>827 Linden Ave</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/28/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn</b>	
24D. LOCATION <b>7225 Eastern Ave, Balto, Md</b>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <b>Austin E. Donovan - 3818 Roland Ave</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

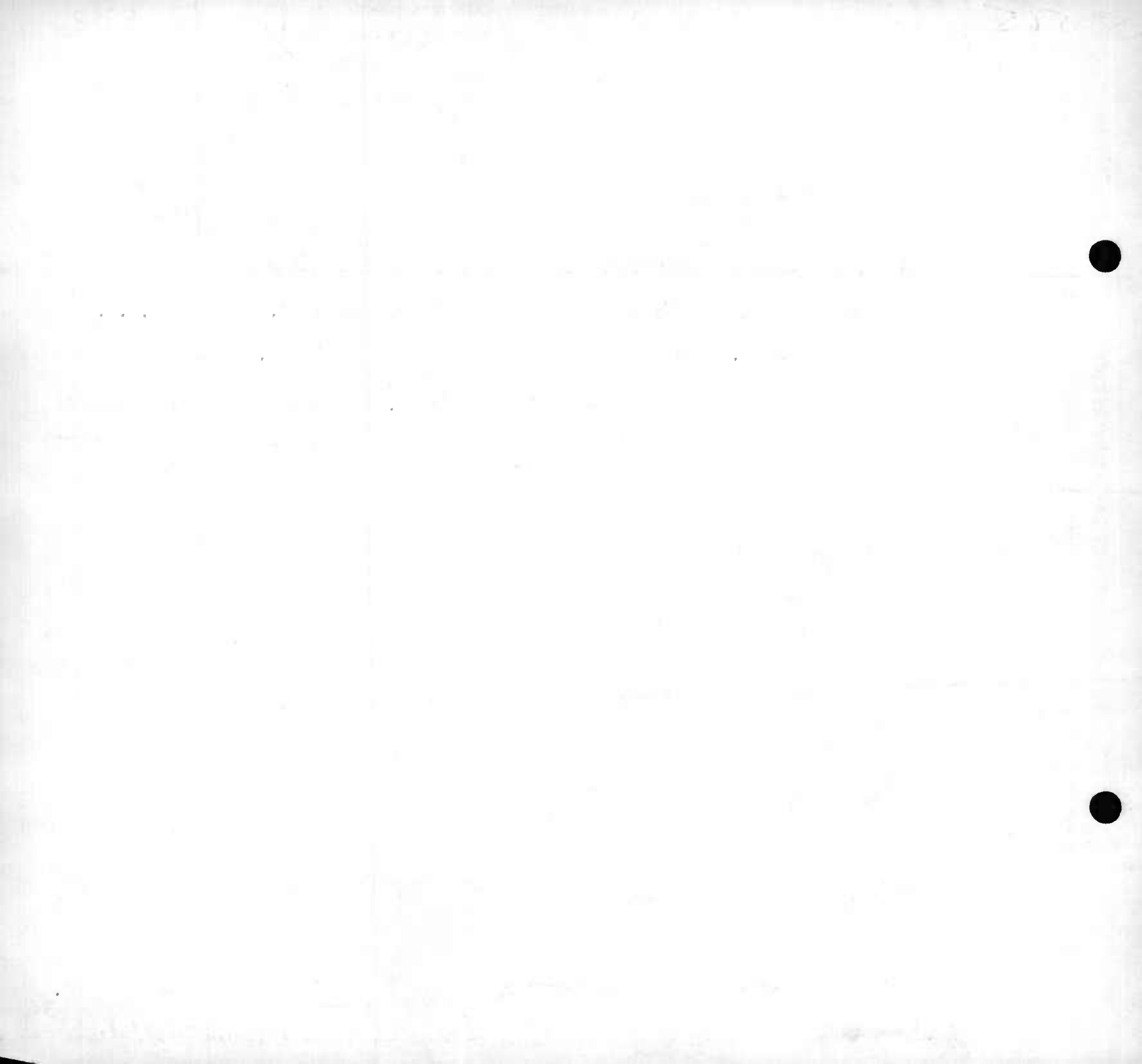
BIRTH NO. 67 6211				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6211	
1. NAME OF DECEASED (Type or Print) <i>Christine C. Moore</i>				2. DATE AND HOUR OF DEATH <i>6-25-1967 2:00 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Church Home &amp; Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i> 21222 D. STREET ADDRESS (If rural, give location) <i>8200 Bull neck Rd</i>			
5. SEX <i>female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>		8. DATE OF BIRTH <i>12/26/1884</i>	9. AGE (In years lost birthday) <i>82</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Karman</i>				14. MOTHER'S MAIDEN NAME <i>Christine Ledder</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>217-54-2477</i>		17. INFORMANT ADDRESS <i>Mary Moore, same as #4</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Massive Intestinal gangrene</i>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <i>Asterosclerosis</i> <i>? Acute Pyocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>(C)</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6-9</i> 19 <i>67</i> to <i>6-25</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6-25</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Rodilio M. Lim</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-25-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Rodilio M. Lim</i> M.D.				23D. ADDRESS <i>Church Home &amp; Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/29/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Co., Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 28 1967</i>		25B. NAME OF REGISTRAR <i>R. E. E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Walter Brooks Bradley, Inc. Dundalk</i>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

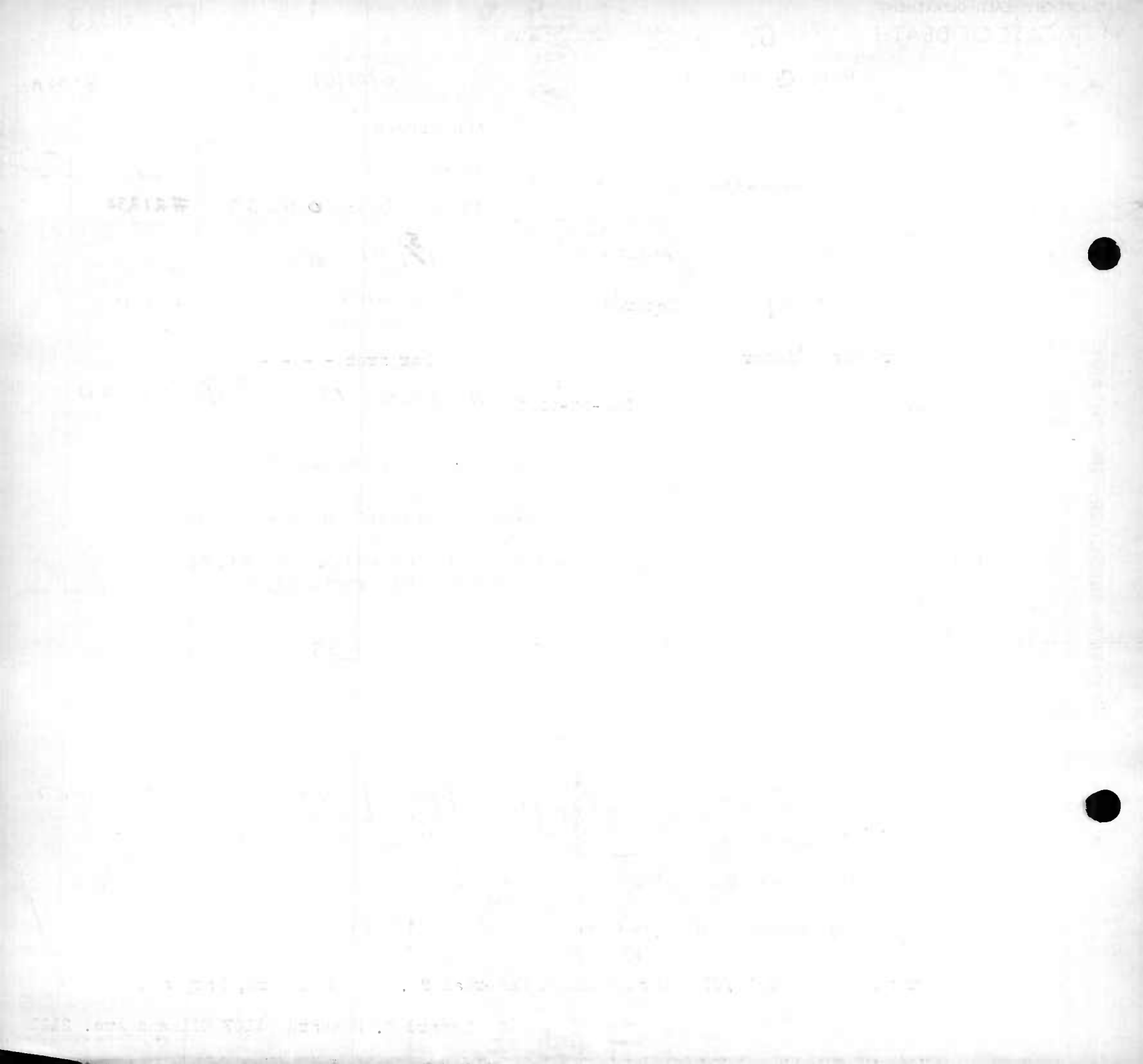
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6212	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 67 6212</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>SOMMERMAN</u> <u>ELSIE</u>			<b>2. DATE AND HOUR OF DEATH</b> <u>6/27/67</u> <u>5:30</u> M.		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital</u>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Balt</u> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>33-00</u> <b>D. STREET ADDRESS</b> (If rural, give location) <u>4404</u> <u>FITCH</u> <u>AVE - 36</u>		
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	<b>8. DATE OF BIRTH</b> <u>2-21-94</u>	<b>9. AGE</b> (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore County Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>Robert E. Fitch</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Ella A. Grammer</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>215-24-7000</u>	<b>17. INFORMANT ADDRESS</b> <u>Maurice F. Sommerman 4404 Fitch Avenue 36</u>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ca lung</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>CAUSE OF DEATH</b> (A) DUE TO (B) DUE TO (C)		
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>6-18</u> <u>1967</u> <b>to</b> <u>6-27</u> <u>1967</u> , <b>that (I) (we) lost saw the deceased alive on</b> <u>6-27</u> <u>19</u> <u>67</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Stephen Gordon</u>				<b>23B. DATE SIGNED</b> <u>6/27/67</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type)		<b>23D. ADDRESS</b>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>6-29-1967</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Farkwood Cemetery</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore</u> <u>Md.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JUN 28 1967</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Fitch</u>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> <u>Lassal Jones 7401 Belair Road</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6213</b>	
BIRTH NO. <b>67 6213</b>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>PAUL C. WINTER</b>		2. DATE AND HOUR OF DEATH <b>6/25/67 3:55 AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL OF MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>25-52</b> D. STREET ADDRESS (If rural, give location) <b>1805 DESOTO ROAD #2130</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3/2/07</b>	9. AGE (In years lost birthday) <b>60</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Norrell Pt. Dairy</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Christian Winter</b>		14. MOTHER'S MAIDEN NAME <b>Margaret - - -</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-32-9352</b>		17. INFORMANT ADDRESS <b>DeSoto ALVENA . 1805 DESOTO ROAD</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>260X I</b>		CAUSE OF DEATH (A) <b>CEREBRO VASCULAR ACCIDENT</b> DUE TO (B) <b>HYPERTENSIVE ARTERIOSCLEROSIS</b> DUE TO (C) <b>FIL CARDIO VASCULAR DISEASE - DIABETES MELLITUS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>6/23/1967</b> to <b>6/25/1967</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>6/25/1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> (did) (did not) view the body after death.					
23A. SIGNATURE <b>V. Biswanath Pillai</b> M.D.				23B. DATE SIGNED <b>6/25/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>V. BISWANATH PILLAI</b> M.D.				23D. ADDRESS <b>730 ASHBURTON STREET</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/28/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadow Ridge Memorial Pk.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard 4107 Wilkens Ave. 21229</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6214</b>	
BIRTH NO. <b>67 6214</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CATHERINE E. MUNNINGS</b>		2. DATE AND HOUR OF DEATH <b>6/23/67 4:45 PM</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>40 ST. AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21227</b> D. STREET ADDRESS (If rural, give location) <b>4611 LINDEN AVENUE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>07/15/08</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOHN STROMBERG</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN Annie Steaver</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-22-4928</b>		17. INFORMANT <b>ST AGNES RECORDS WILKENS</b> ADDRESS <b>88 CATON AVENUE</b>	
18. <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Terminal phase of Ca of Breast</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6/23/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>X</b> (this hospital) attended the deceased from <b>6/13/67</b> 19 to <b>6/23/67</b> 19 that <b>XX</b> (we) last saw the deceased alive on <b>6/23/67</b> 19 <b>4:45 PM</b> and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. A. Sonmez</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>DR. A. SONMEZ</b>				23D. ADDRESS M.D. <b>1011 Frederick Road. Balt. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/27/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION <b>Baltimore</b>		24E. LOCATION <b>Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>	
				ADDRESS <b>21229 4107 Wilkens Ave.</b>	

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67 6215		BALTIMORE CITY HEALTH DEPARTMENT		67 6215	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
MARTHA A. MORTON		6-26-67		12:55 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY			
4204 WICKFORD ROAD		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4204 Wickford Road 21210			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	White	MARRIED	JUNE 22, 1887	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		HOME	MARYLAND		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
FRANKLIN C. LOFLIN			OCTAVIA GAITHER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
No			ALFRED B. MORTON		SAME
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
(A) Arteriosclerotic cardiovascular disease					
DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
(B) DUE TO					
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		6-26-67	
RUSSELL S. FISHER, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
CREMATION		6/26/67		GREEN MOUNT	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
JUN 28 1967		Robert E. Fisher, M.D.		MITCHELL-WIEDEFELD HOME	
				ADDRESS	
				6500 YORK RD. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 6216</span>	
BIRTH NO. <span style="float: right;">67 6216</span>		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>ELIZABETH WASIEWSKI</b>			2. DATE AND HOUR OF DEATH <b>6/26/67 5:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME &amp; HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>220 S. CHAPEL ST</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11/16/16</b>	9. AGE (In years lost birthday) <b>50</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIRT PRESSER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Shirt Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>John Auffarth</b>			12. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>			16. SOCIAL SECURITY NO. <b>213-10-1950</b>		
17. INFORMANT <b>Mr. Adam J. Wasiewski, 220 S. Chapel St.</b>			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SEPTIC PERITONITIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HEART FAILURE</b> <b>Biliary Cirrhosis</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>					
19A. DATE OF OPERATION <b>6/19/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Biliary Cirrhosis</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>5/29</b> 19 <b>67</b> to <b>6/26</b> 19 <b>67</b> , that (I) <b>(did)</b> last saw the deceased alive on <b>6/26</b> 19 <b>67</b> and that in (my) <b>(did)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Merwin L. Trail</b>				23B. DATE SIGNED <b>6/26/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Merwin L. Trail</b>				23D. ADDRESS <b>Church Home &amp; Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/29/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>			
25B. NAME OF REGISTRAR <b>John E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>			

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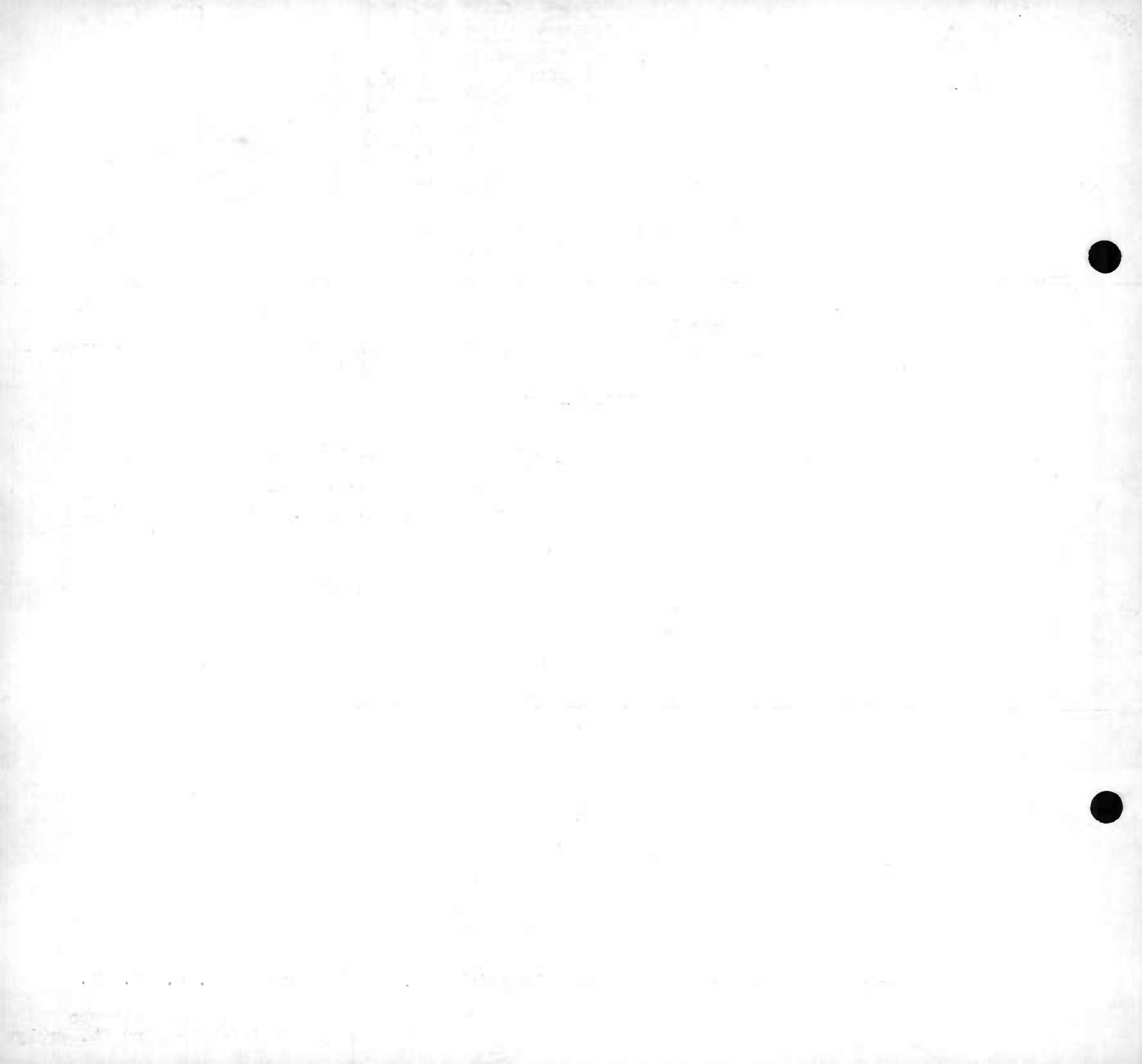
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6217		67 6217		67 6217	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Margaret Madeline DAWSON		PM 6/26/67 1.00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
Franklin Square Hospital		A. STATE Maryland B. COUNTY			
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Baltimore, Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
McNeal HARRY B. <del>XXXXXXXXXX</del>		Kathryn Frailer		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-01-5307		Medical chart	
18. 443X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		ARTERIO SCLEROTIC			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		HYPERTENSIVE CARDIOVASCULAR DISEASE			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/18 to 6/26 1967, that (I) (we) last saw the deceased alive on 6/26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Raymundo S. Magno M.D.		6/26/67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
RAYMUNDO S. MAGNO M.D.		Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		6/29/67		Glen Haven Memorial Inc.	
				Glen Burnie A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 28 1967		Robert E. Faldut		McCully Funeral Home Patapsco & 3rd St. Bklyn	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6218	
BIRTH NO. 67 6218		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNA Rushefsky (or Rusiecki)		2. DATE AND HOUR OF DEATH June 26, 1967 4:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission) A. STATE Maryland		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital		D. STREET ADDRESS (If rural, give location) 423 N. East Ave		26-10	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/15/94	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Ukraine	
13. FATHER'S NAME Simon Pwkopeswk		14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-54-5690-1		17. INFORMANT Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Congestive Heart failure (B) A.S.C.V. Disease (C) Pulmonary Emphysema		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 25, 1967 to June 26, 1967, that (I) (we) last saw the deceased alive on June 26, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Dr. J. H. Hino		23B. DATE SIGNED June 26, 1967	
23C. PHYSICIAN'S NAME (Type) J. H. HINO		23D. ADDRESS M.D. 5002 Frankford Ave. Balt.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/67		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 28 1967		25B. NAME OF REGISTRAR E. E. E. E.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25D. ADDRESS 3331 Brehms Lane			

H B O X *Chart* 22-22-45 22

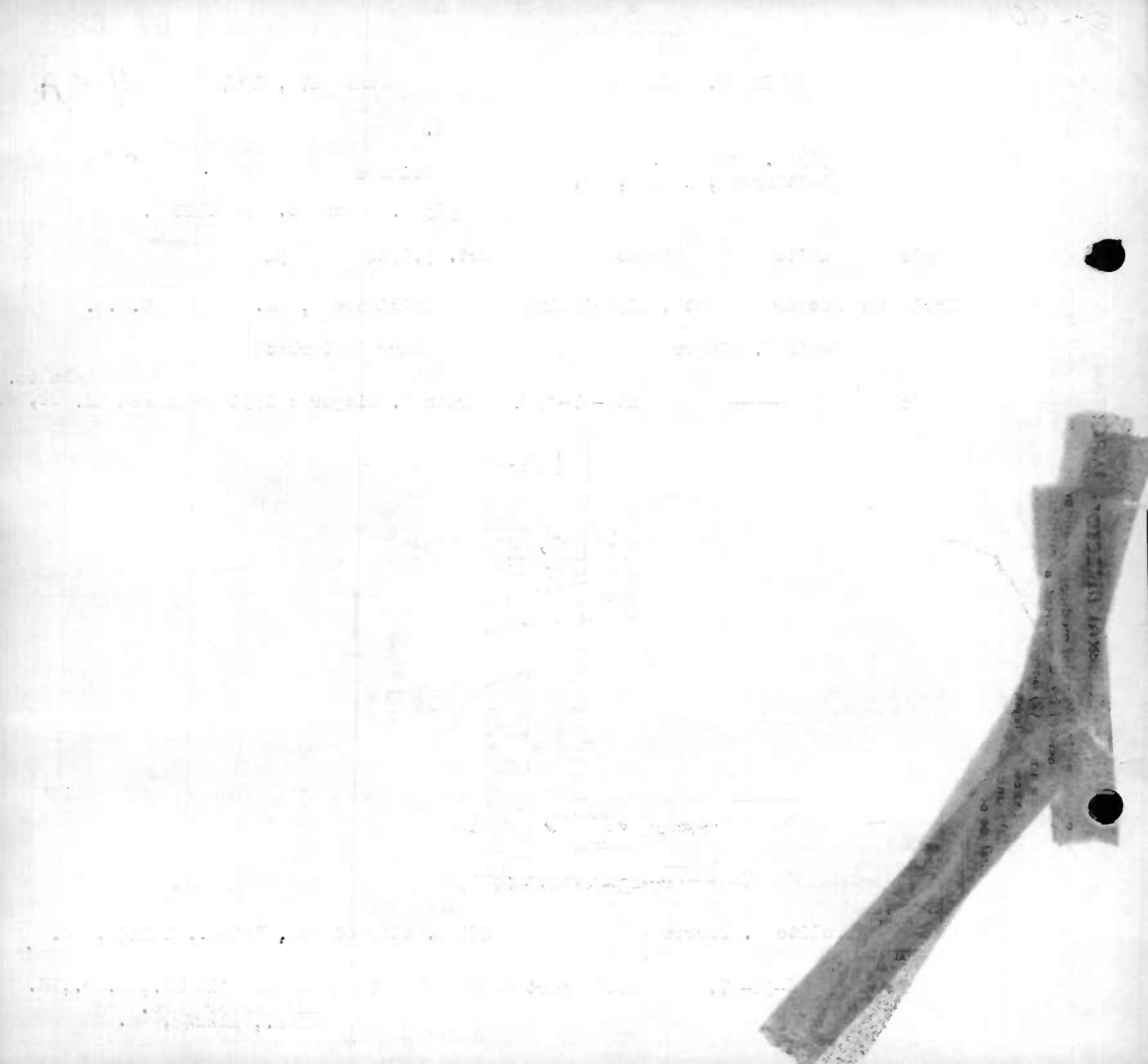
February 20, 1900  
10:30 a.m.  
Competitive Heart Failure

Four 2 1/2 hour 521401

*[Handwritten signature]*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); or (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 67 6219					CERTIFICATE OF DEATH					Registered No. 67 6219						
1. NAME OF DECEASED (Type or Print) <b>LOUIS J. BIEGER</b>					2. DATE AND HOUR OF DEATH <b>June 27, 1967</b> <b>11:00 A.M.</b>											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>515 S. Macon St. Baltimore, 21224, Md.</b>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>515 S. Macon St. # 21224.</b>											
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>		8. DATE OF BIRTH <b>Oct. 9, 1914</b>		9. AGE (In years last birthday) <b>52</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool Room Keeper</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Shipbuilding</b>					11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis J. Bieger</b>					14. MOTHER'S MAIDEN NAME <b>Mary Lauterbach</b>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>218-07-3962</b>					17. INFORMANT <b>Warren P. Bieger : 1931 Robinwood Rd. 22, Md.</b>					ADDRESS <b>Balto.</b>	
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Heart Disease</b>					CAUSE OF DEATH <b>Arteriosclerotic Heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>					DUE TO <b>Possible Liver Cirrhosis</b>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?											
22. I certify that (I) (this hospital) attended the deceased from <b>January 21, 1967</b> to <b>January 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>January 28, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																
23A. SIGNATURE <b>Melito M. Torres, M.D.</b>					23B. DATE SIGNED <b>6-28-67</b>											
23C. PHYSICIAN'S NAME (Type) <b>Melito M. Torres</b>					23D. ADDRESS <b>441 S. Ellwood Ave. Balto., 21224, Md.</b>											
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-30-67.</b>		24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>7401 German Hill Rd., Ba. Co., Md.</b>									
25A. NAME of HEALTH DEPT. <b>Baltimore</b>					25B. NAME of REGISTRAR <b>Charles E. Taylor</b>					25C. FUNERAL DIRECTOR ADDRESS <b>6224 Eastern Ave. Balto., 21224, Md.</b>						



# FUNERAL DIRECTOR: IMPORTANT

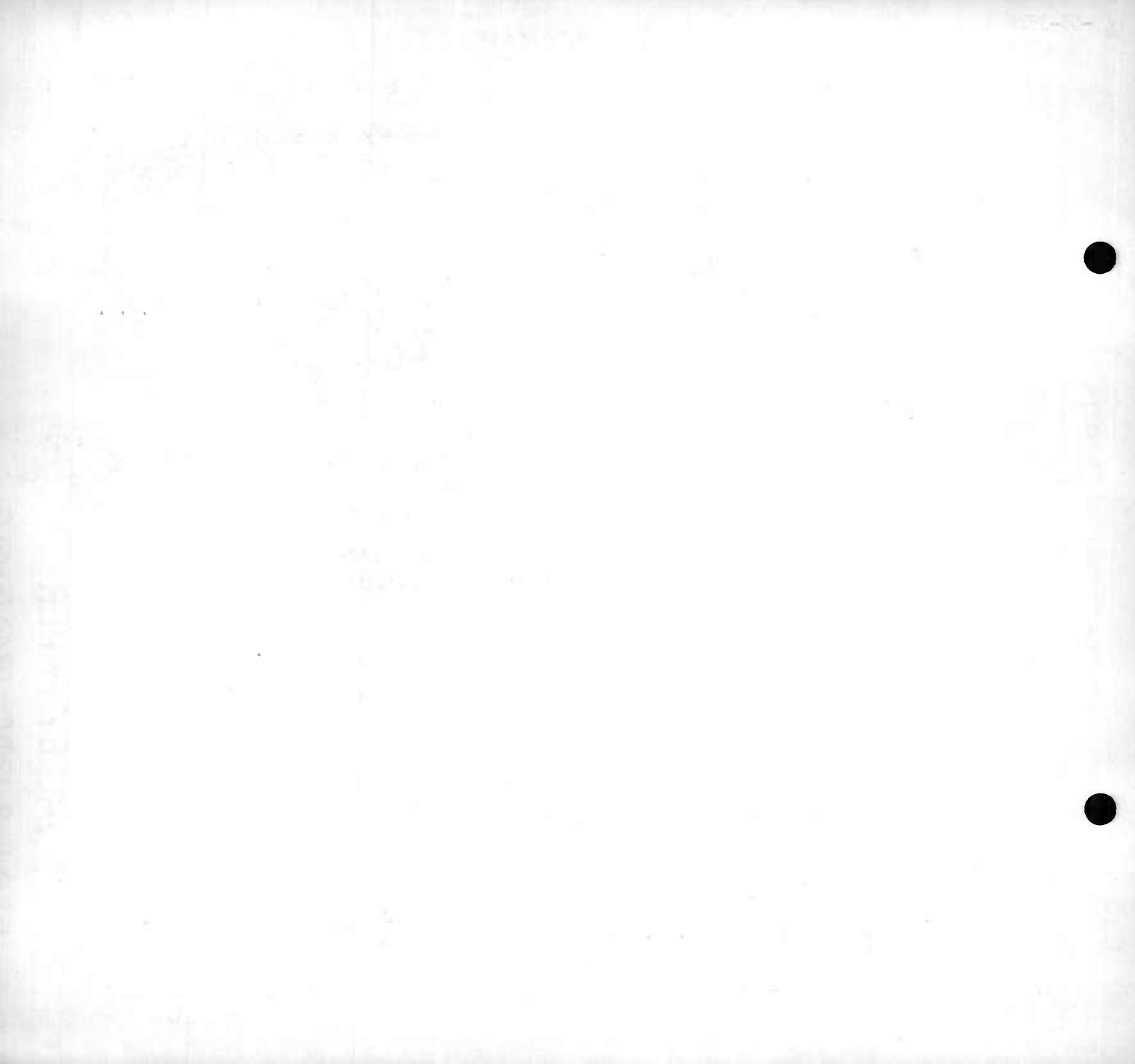
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6220				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6220	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>SMITH ERLIE</b>		2. DATE AND HOUR OF DEATH <b>6-27-67 10-30A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital of Maryland</b>				A. STATE <b>Maryland</b>		B. COUNTY <b>Baltimore</b>	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		16-06	
D. STREET ADDRESS (If rural, give location) <b>612 N. Dukeland St.</b>							
5. SEX <b>Male</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>4-12-1912</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hamlet N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Preston Smith</b>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-4542</b>		17. INFORMANT <b>Iada Smith</b>		ADDRESS <b>612 N. Dukeland St. wife</b>	
18. <b>331X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebro Vascular haemorrhage</b>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>Hypertension</b>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6-25-1967</b> to <b>6-27-1967</b> , that (I) (we) last saw the deceased alive on <b>6-27-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Anil M Joshi</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/27/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ANIL M JOSHI</b>				23D. ADDRESS <b>Lutheran Hospital of Maryland 730 Ashburton St. 21216</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-30-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>W. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JUN 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltman</b>		25C. FUNERAL DIRECTOR <b>C. Wainwright</b>		ADDRESS <b>2700 Edmondson</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-11892 67 6221		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6221	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HELEN, GIRL JONES		2. DATE AND HOUR OF DEATH 6-23-67 12:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		D. STREET ADDRESS (If rural, give location) 2535 GARRETT AVENUE 21218		E. CITY OR TOWN Baltimore Md. 21218	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 6-22-67	9. AGE (In years last birthday) 26	10. If Under 1 Yr. Months: Days: Hours: Min. 15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Helen Jones		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT BCH:RECORDS 4940 EASTERN AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 762.5 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) RESPIRATORY DISTRESS SYND. + APNEA (B) PREMATUREITY, % INTRA-CRANIAL HEMORRHAGE, TRAUMATIC DELIVERY (C) after birth		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-22-67 19 to 6-23-67 19 that (I) (we) last saw the deceased alive on 6-23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. McHugh		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-23-67	
23C. PHYSICIAN'S NAME (Type) E. MC HUGH DR. E. MC HUGH		23D. ADDRESS 4940 EASTERN AVENUE BALTO. MD. 21224 Baltimore City Hospital Building			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6-26-67		24C. NAME of CEMETERY or CREMATORY Baltimore City Hospitals	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224		25A. DATE REC'D BY HEALTH DEPT. JUN 28 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		25D. ADDRESS			

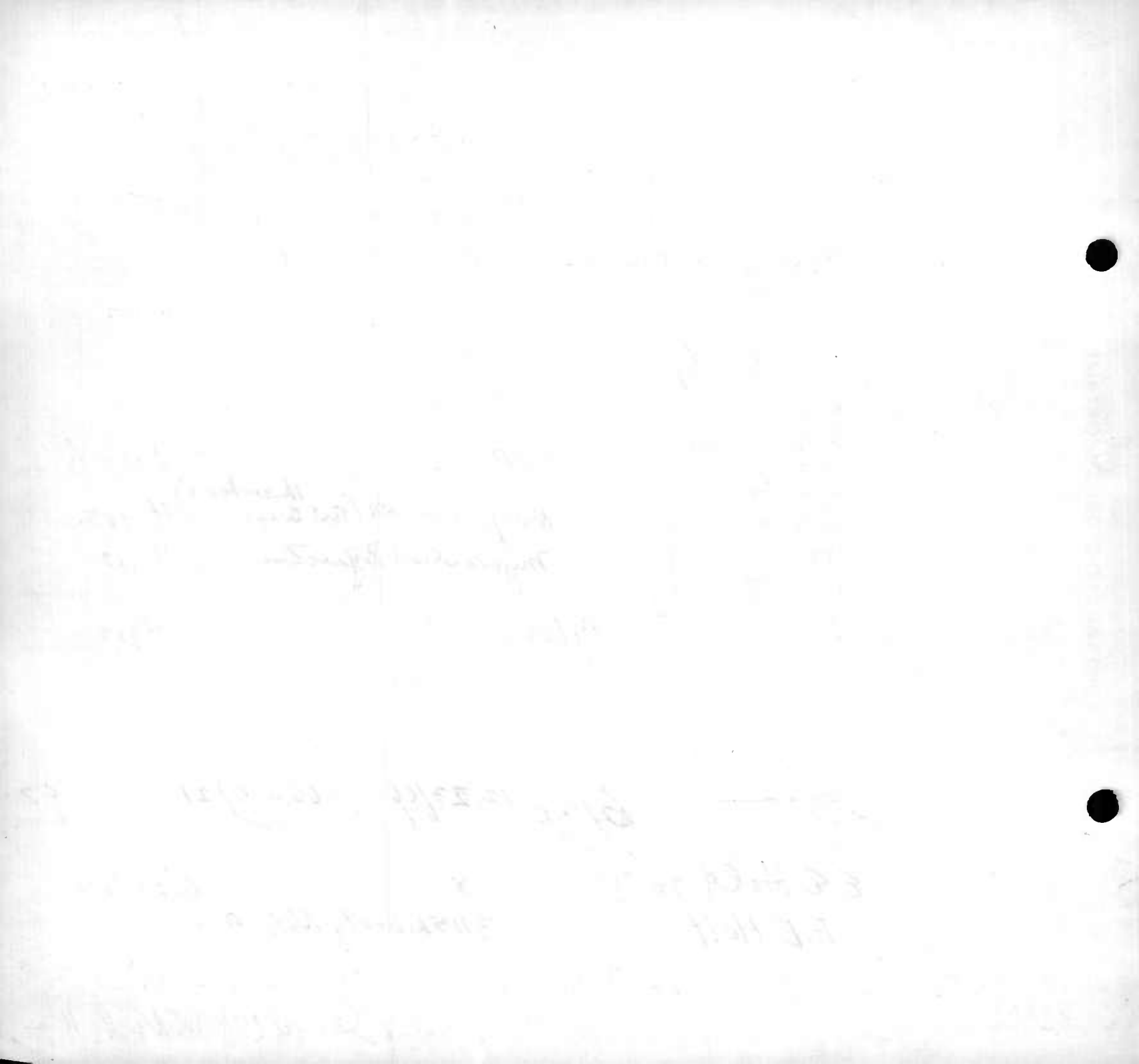




FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6222	
BIRTH NO. 67 6222		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Joseph Handy</i>		2. DATE AND HOUR OF DEATH <i>6-21-67 12:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>GEORGE WASHINGTON Nursing Home</i>		A. STATE <i>MARYLAND</i> B. COUNTY <i>1802</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1101 W. Vine Street</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>? 1887 79</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Handy</i>			14. MOTHER'S MAIDEN NAME <i>MARY Handy</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Chart # 646 607 Penna Ave</i>	
18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>CVA</i> DUE TO (B) <i>Hemiparesis, Rt (Post Cerebral Thrombosis)</i> DUE TO (C) <i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>4 yrs.</i> <i>4 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Aphasia</i>		<i>4 yrs.</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>12/23/66</i> 19 <i>66</i> to <i>6/21</i> 19 <i>67</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>6/20</i> 19 <i>67</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>E.E. Holt, M.D.</i> M.D.				23B. DATE SIGNED <i>6/22/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>E.E. Holt</i>				23D. ADDRESS M.D. <i>3715 Liberty Hts. Ave.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/28</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Calvary</i>	
24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 28 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i>	
25C. FUNERAL DIRECTOR <i>Rev. J. Carroll</i>		25D. ADDRESS <i>1712 W. North Ave</i>			



1  
5.363

67 6223

BALTIMORE CITY HEALTH DEPARTMENT

67 6223

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHRISTOPHER

C.

STEWART, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

June 27, 1967

9:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2223 Orleans Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2223 Orleans Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

11-28-1893

9. AGE (In years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

MAINTENANCE

10B. KIND OF BUSINESS OR INDUSTRY

HOSPITAL

11. BIRTHPLACE (State or foreign country)

GEORGIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE STEWART

14. MOTHER'S MAIDEN NAME

LINDA -

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Ruby Pearson - 2223 E. Orleans St.

18. 4-22-1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/27/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

7-1-67

23C. NAME of CEMETERY or CREMATORY

UTAH CEMETERY

23D. LOCATION

(City, town, or county)

(State)

PEARSON, GEORGIA

24A. DATE REC'D BY HEALTH DEPT.

JUN 28 1967

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Arthur G. Geller - 2334 Jefferson St.

ADDRESS

13

11-28-1943

MAILED

RECEIVED

HOSPITAL

MAINTENANCE

LINE -

STEWART

GEORGE

NO

11-28-1943

RECEIVED 11-28-1943

11-28-1943

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6224</b>	
BIRTH NO. <b>67 6224</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Constance Crique</b>		2. DATE AND HOUR OF DEATH <b>June 26, 1967 12:50 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1504</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</b>		D. STREET ADDRESS (If rural, give location) <b>1939 Ridgehill Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11-15-28</b>	9. AGE (In years lost birthday) <b>38 yrs.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>(New York) Kircsh Beverages</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Melvin Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Julia Ringgold</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Reginald - husband</b>	
18. <b>332X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 25, 1967</b> to <b>June 26, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 26, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-26-67</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. <b>1514 Division Street Balto., Maryland</b>			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<b>Buried 7/1/67</b>		<b>7/1/67</b>		<b>Mount Auburn</b>	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
<b>Baltimore MD</b>		<b>Charles A. Rice 661W Baring</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>JUN 28 1967</b>		<b>Robert E. Taylor, M.D.</b>		<b>Charles A. Rice</b>	

John R. King

John R. King

John R. King

John R. King

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6225				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6225	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) JOHNSON HENRY L.				6-26-67		9 40 pm M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
34 BON SECOURS HOSPITAL				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				2018 W. FAYETTE ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
M	NEGRO	MARRIED	9-18-14	52			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
INSPECTOR		HOL-TITE MANUF. CO.		GEORGIA		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
OSCAR JOHNSON				MERRICKS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				Nozella Johnson		2018 W. Fayette St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				Cardiac Arrest due to Acute Myocardial Infarction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 26 19 67 to June 26 19 67, that (I) (we) last saw the deceased alive on June 26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Jung Kook Lee						6-26-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Jung Kook Lee				Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/29/67		Catholics Men PK		Catholics Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 28 1967		Robert E. ...		Charles A. ...		6616 Barrett	

100-1000

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BIRTH NO. **57 6226** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **57 6226**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN T. MICOLOWSKI</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>June 27, 1967 10:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Near 1300 Block E. Clement Street</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1402 Haubert Street</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>9/14/55</b>	9. AGE (In years last birthday) <b>11</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. Micolowski</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Peterson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>John T. Micolowski 1402 Haubert St.</b>			
18. CAUSE OF DEATH <b>E924.5</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Suffocation by plastic bag pulled over face</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>June 26, '67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>UNK</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Near 1300 Block E. Clement Street</b>			
21D. TIME OF INJURY (APPROX.) <b>June 26, '67 UNK</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Suffocation while sniffing glue</b>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/26/67</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>7/1/67</b>		23C. NAME of CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue</b>			

ALLEY FORD

CONCORD, N.H.

*Handwritten signature*

BIRTH NO.

6227

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67

6227

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EDWARD

HORN

2. DATE AND HOUR PRONOUNCED DEAD

6-25-67

5:10 PM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5 S. Chester Street 21231

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

10/8/17

9. AGE (In years  
last birthday)

XX 49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Wilmar Horn

14. MOTHER'S MAIDEN NAME

MXX Anna McCormick

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL  
SECURITY NO.

?

17. INFORMANT

ADDRESS

Prevatt Funeral Home Fairmont, N.C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

R56.0

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

with acute myocardial infarction

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-26-67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/28/67

23C. NAME of CEMETERY or CREMATORY

Horn Family Cemetery

23D. LOCATION

(City, town, or county)

Robeson Co, N.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 28 1967

R. E. Fisher

Wm. Cook-Brooks Inc. Baltim



RECEIVED FOR



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6228				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6228			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH				M.			
1. NAME OF DECEASED (Type or Print) FRANCES B. DAVIS				6-26-67/9 50 P M							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE MARYLAND							
APT. 4B PRESTON APTS.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)							
				BALTIMORE				11-01			
D. STREET ADDRESS (If rural, give location)				APT. 4B PRESTON APTS., PRESTON & GUILFORD							
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 7/25/1890		9. AGE (In years lost birthday) 76		10. If Under 1 Yr. Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ft. Clarke, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME MALVERIN H. BARNUM				14. MOTHER'S MAIDEN NAME MARTHA Mc GUINNESS							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 216-46-4147		17. INFORMANT ADDRESS N. J. Alanson B. Davis 18 Manor Hill Rd. Summit					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO Generalized arterio-sclerotic CV disease				INTERVAL BETWEEN ONSET AND DEATH Years			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO							
				(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from July 1965 to 2-26 1967, that (I) (we) last saw the deceased alive on 6-20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE R K Gundry M.D.				23B. DATE SIGNED 6-28-67							
23C. PHYSICIAN'S NAME (Type) GUNDRY, Richard K., M.D.				23D. ADDRESS 2 West University Parkway, 21218							
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 6/29/67		24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) Baltimore, Md.					
25A. DATE RECEIVED BY HEALTH DEPT. JUN 28 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1217 St							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6229		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6229	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Rosalee Bacote (AKA Rosalie)</b>		2. DATE AND HOUR OF DEATH <b>June 23, 1967</b>		<b>11:45p.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b> 1514 Division Street Baltimore, Maryland 21217		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>16-03</b> D. STREET ADDRESS (If rural, give location) <b>1613 Riggs Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>6-26-1916</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Empire Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Unknown Robert Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Sallie Webb</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>255-36-3628</b>		17. INFORMANT <b>Ernest Miles-friend</b>	
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Heart Arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hemorrhagic Cardiovascular Accident</b> <b>Hypertension</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6/28/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 23, 1967</b> to <b>June 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 23, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lizarazo</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>June 24, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lizarazo</b>		23D. ADDRESS M.D. <b>1514 Division Street-Baltimore, Maryland-17</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/28/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery Baltimore</b>	
24D. LOCATION (City, town, or county)		25A. DATE RECEIVED BY HEALTH DEPT. <b>JUN 28 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR <b>Joseph L. Rues 2222</b>			

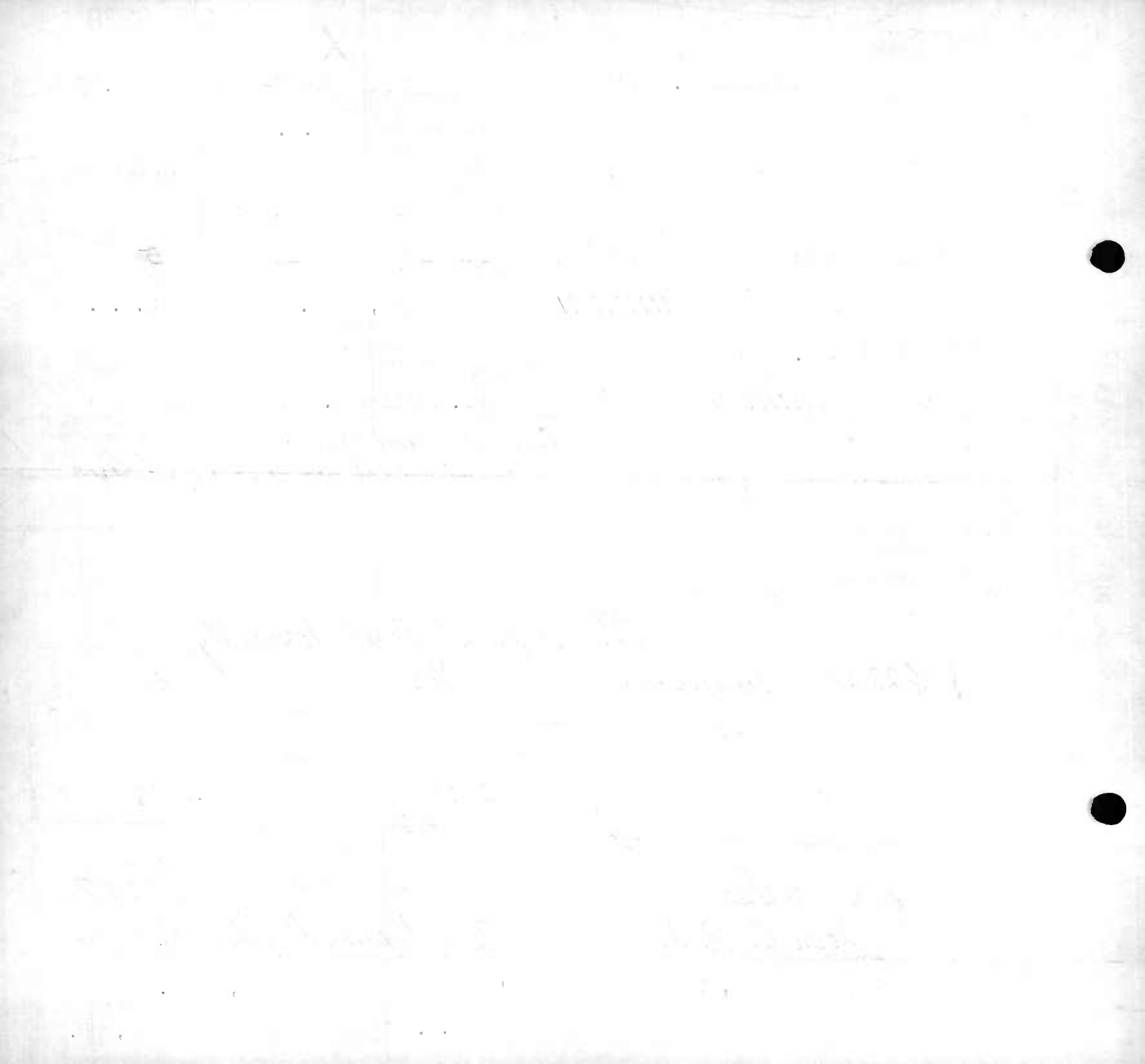
Lizandro



FUNERAL DIRECTOR: IMPORTANT

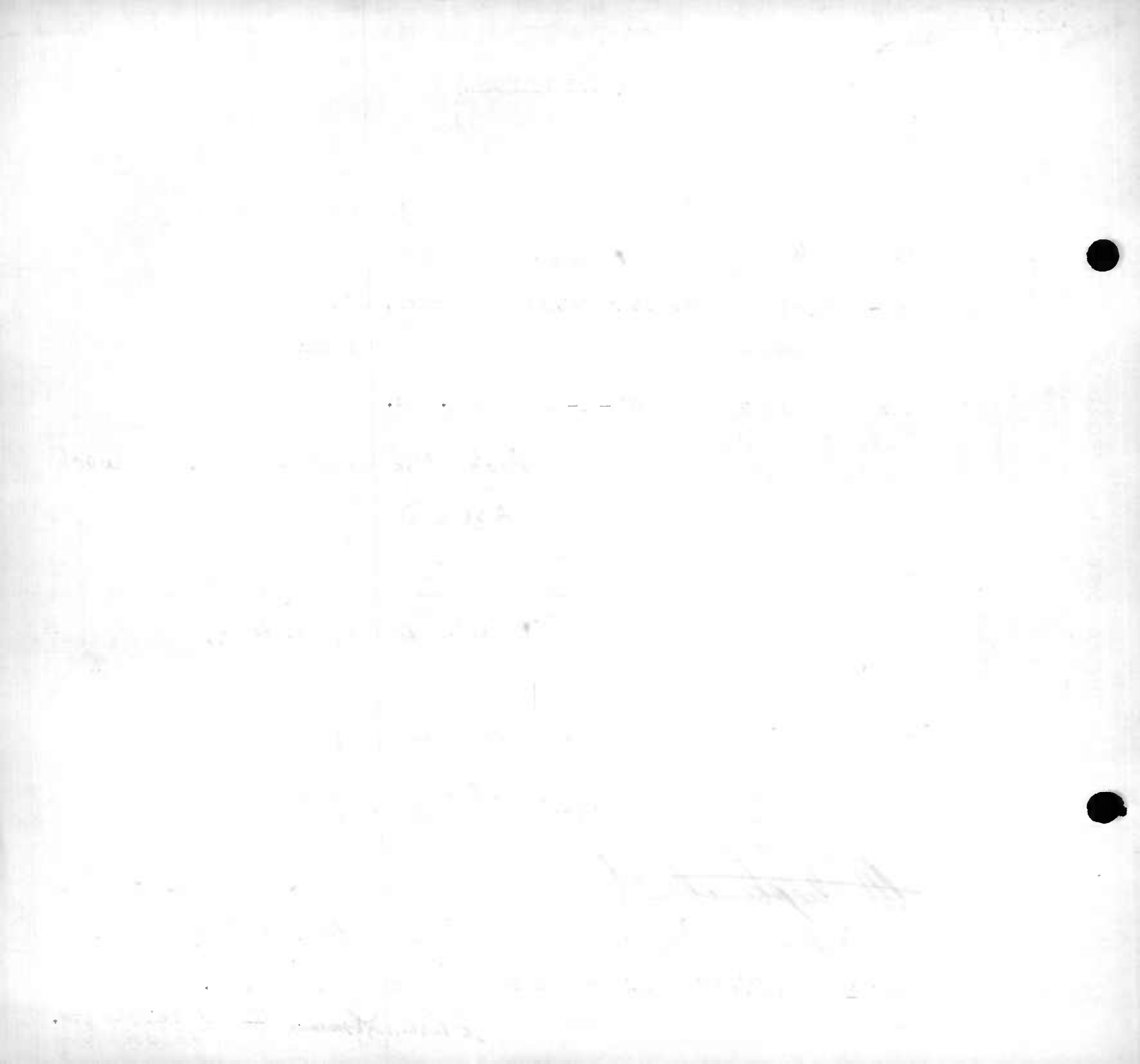
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">67 6230</span>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">67 6230</span>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>CHARLES R. OCHS</b>				2. DATE AND HOUR OF DEATH <b>6-25-67</b>   <b>2.25 A M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>A.A.</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>PASADENA</b> <span style="float: right;">52-00</span>			
				D. STREET ADDRESS (If rural, give location) <b>BOX #400 WOODS ROAD</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>		8. DATE OF BIRTH <b>6-20-67</b>	9. AGE (In years lost birthday) <b>--</b>	If Under 1 Yr. Months <b>5</b>	If Under 24 Hrs. Hours <b>25</b> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>//////////</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM L. OCHS</b>				14. MOTHER'S MAIDEN NAME <b>HESTER FAGUE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b> <b>//////////</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mr. William L. Ochs</b>		ADDRESS <b>Same as # 4</b>	
18. <b>754.71</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <b>Congenital Heart Disease</b> <b>Transposition of Great Vessels</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
				(A) DUE TO			
				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b> <b>? Congenital Renal Abnormality</b>							
19A. DATE OF OPERATION <b>6-23-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Transposition</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>---</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>---</b>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>---</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>---</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>6-21</b> <b>1967</b> to <b>6-25</b> <b>1967</b> , that (I) <b>(we)</b> lost saw the deceased alive on <b>6-25</b> <b>1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> (did) (did not) view the body after death.							
23A. SIGNATURE <b>L. C. Parks</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-25-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Leon C. Parks</b>				23D. ADDRESS <b>Johns Hopkins Hospital, Balt. Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JUNE 27, 67</b>		24C. NAME OF CEMETERY or CREMATORY <b>GLEN HAVEN MEM'L PARK</b>		24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		25B. NAME OF REGISTRAR <b>R. V. Singleton</b>		25C. FUNERAL DIRECTOR <b>R. V. SINGLETON</b>		ADDRESS <b>GLEN BURNIE, MD.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6231</u>
BIRTH NO. <u>67 6231</u>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Leroy Pickerel (LEROY PICKEREL)</u>		2. DATE AND HOUR OF DEATH <u>June 27th 1967 1.30 A. M.</u>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Sinai Hospital of Baltimore</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
D. STREET ADDRESS (If rural, give location) <u>4525 Homer Ave</u>		27-16		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>5/6/13</u>	9. AGE (In years lost birthday) <u>54</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Pest Extermination</u>		11. BIRTHPLACE (State or foreign country) <u>Canton, Ohio</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes W # 2</u>		16. SOCIAL SECURITY NO. <u>279-05-4540</u>		17. INFORMANT <u>Hosp. Rec.</u>
18. <u>4-20-19-260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u>		CAUSE OF DEATH (A) DUE TO <u>ASCVD</u> (B) DUE TO <u>Unknown</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes Mellitus Adult type Unknown</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> 19 <u>67</u> to <u>6/27</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/27</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>William Cieplinski</u> M.D.				23B. DATE SIGNED <u>6/27/67</u>
23C. PHYSICIAN'S NAME (Type) <u>William Cieplinski</u>		23D. ADDRESS <u>Sinai Hospital of Baltimore</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/29/1967</u>	24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR <u>B. Vernon Lamm</u>	
ADDRESS <u>4611 Park Heights Ave.</u>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6232</b>	
BIRTH NO. <b>67-12126 67 6232</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>STEVEN STEPHEN CHARLES PRINCE</b>		2. DATE AND HOUR OF DEATH <b>6-23-67 12<sup>10</sup> P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BON SECOURS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>20-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2018 CHRISTIAN ST.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>-</b>	8. DATE OF BIRTH <b>6-21-67</b>	9. AGE (In years lost birthday) <b>1 1/2</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>WILLIARD THOMAS PRINCE</b>		14. MOTHER'S MAIDEN NAME <b>RITA MAY LEWIS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Hospital Recd</b> ADDRESS	
18. <b>776X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>IMMATURITY</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>6-21 1967</b> to <b>6-23 1967</b> , that (2) (we) lost <u>saw</u> the deceased alive on <b>6-23 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Alejandro A. Melendez</b>		23B. DATE SIGNED <b>6-23-67</b>		23C. PHYSICIAN'S NAME (Type) <b>Alejandro A. Melendez</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/27/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bethel National Cem</b>	
24D. LOCATION <b>Bethel Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Thomas J. Kenny Inc</b>		25D. ADDRESS <b>Bethel Md</b>			

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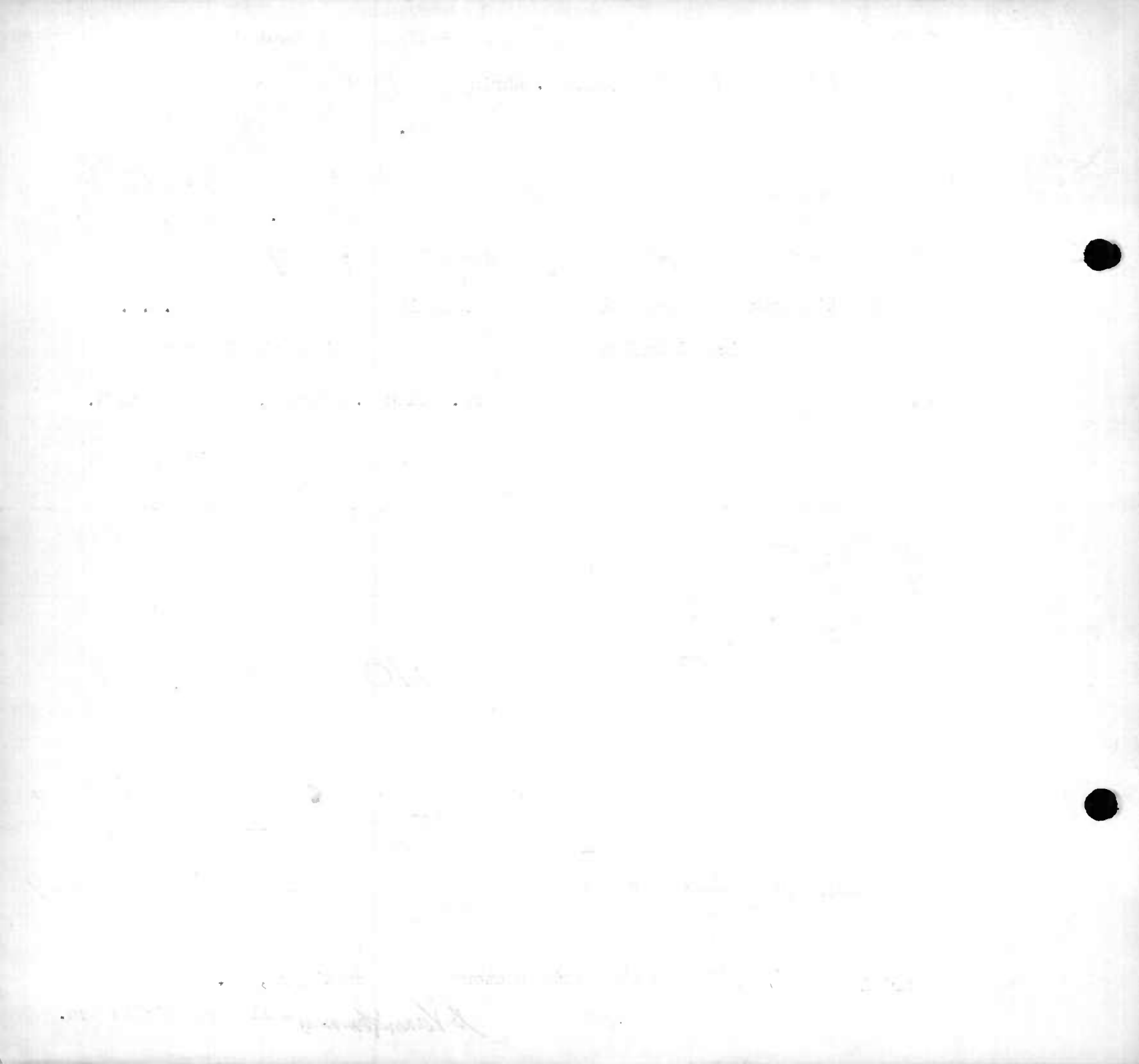
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Date 2/2/20  
No. 1000

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
67 6233 CERTIFICATE OF DEATH					Registered No. 67 6233						
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. _____</p> <p>M.E. CASE NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) <b>ANNA AHRING (Anna M. Ahring)</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <b>JUNE 26, 1967 5:35 P.M.</b></p> </div> </div>											
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <div style="display: flex;"> <div style="flex: 1;"> <p>FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP. OF BALTIMORE, INC.</b></p> </div> <div style="flex: 1;"> <p>(If not in hospital or institution, give street address or location)</p> </div> </div>					<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <div style="display: flex;"> <div style="flex: 1;">A. STATE <b>Md.</b></div> <div style="flex: 1;">B. COUNTY <b>Baltimore</b></div> </div> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b></p> <p>D. STREET ADDRESS (If rural, give location) <b>4521 Homer Ave.</b></p>						
5. SEX <b>MF</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>		8. DATE OF BIRTH <b>AUGUST 2, 1894</b>		9. AGE (In years last birthday) <b>72</b>		<p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Cook</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Household</b>		11. BIRTHPLACE (State or foreign country) <b>Bohemia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Michael Sudina</b>						14. MOTHER'S MAIDEN NAME <b>Elizabeth Linheart</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Helen A. Pfister, 330 Radnor Road.</b>					
<p>18. <b>420.1 I</b> CAUSE OF DEATH</p> <div style="display: flex;"> <div style="flex: 1;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) DUE TO <b>Myocardial Infarction</b></p> <p>(B) DUE TO</p> <p>(C)</p> </div> <div style="flex: 1;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b></p> </div> </div> <p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>											
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
<p>22. I certify that <del>(H)</del> (this hospital) attended the deceased from <b>June 26, 1967</b> to <b>June 26, 1967</b>, that <del>(H)</del> (we) last saw the deceased alive on <b>June 26, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>											
23A. SIGNATURE <b>Francisco D. Sabado, Jr.</b> M.D.								<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>		23B. DATE SIGNED <b>June 26, 1967</b>	
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>6/30/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE RECEIVED BY HEALTH DEPT. <b>JUN 28 1967</b>				25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>				25C. FUNERAL DIRECTOR ADDRESS <b>4611 Park Heights Ave.</b>			

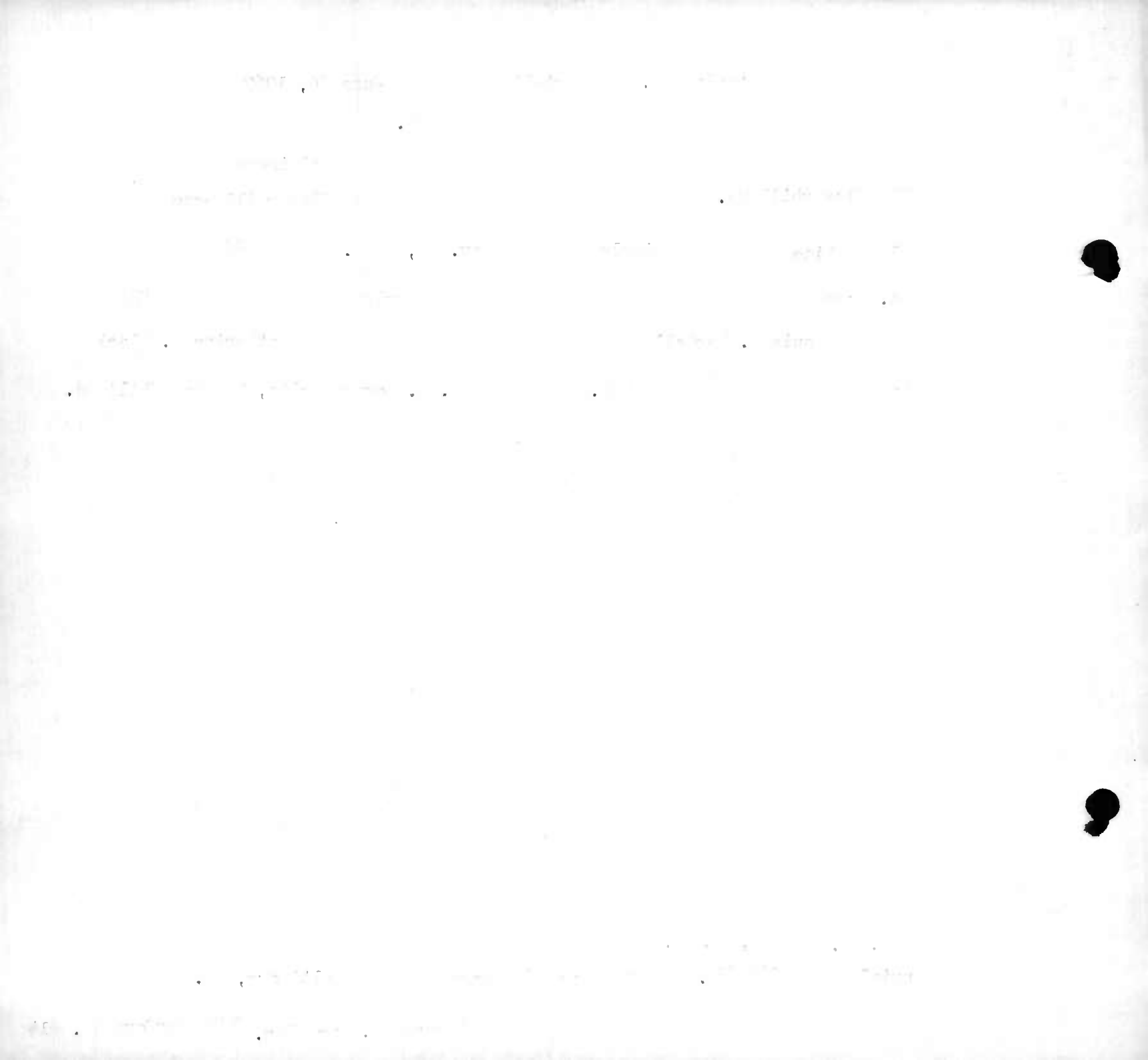




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6234				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6234	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Gisela A. Bartell		June 26, 1967 3:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
3942 Cloverhill Rd.				Md.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				3942 Cloverhill Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
Female	White	Single	Nov. 28, 1880.	86			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
At. Home					Maryland		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Louis E. Bartell				Katherine V. Plack			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No			Unk.		Mr. H. Vernon Nolte, 1302 Roundhill Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.21				Congestive Heart Failure		2-4 days	
ANTECEDENT CAUSES				(A) DUE TO		Advanced Atherosclerosis	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		Disease of Myocardium	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from June 10 1967 to June 26 1967, that (I) (we) last saw the deceased alive on June 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
W. H. Woody, M.D.						6-27-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		M.D.			
		1403 Park and Balto 17 mo					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/29/67.		Loudon Park Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 28 1967		P. E. E. Edwards		Leonard J. Rueck, Inc.		5305 Harford Rd. #14	



M-242

## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 6235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6235

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM G. MICHALLAS</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>June 27, 1967 12:45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Johns Hopkins Hospital (DOA)</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Harford</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Joppa 21085</b> D. STREET ADDRESS (If rural, give location) <b>2307 <del>Reckford Road</del> Reckord Road</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>July 4, 1923.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Resturant Owner</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>43</b>
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Michallas</b>		14. MOTHER'S MAIDEN NAME <b>Anna Kokinous</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW2</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Belle Michallas</b>		ADDRESS <b>(Same)</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenic, etc. It means the disease, injury or complication which caused death.) <b>(A) Multiple Injuries</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B) DUE TO</b> <b>(C) DUE TO</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>June 27 '67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21C. WHERE DID INJURY OCCUR? <b>Route 40 West of Jones Road</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>June 27 '67 12:07 a.m.</b>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Car swayed, went up a bank, and turned over.</b>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>6/26/67</b> EXAMINER'S NAME (Type)			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>6/30/67.</b>	23C. NAME of CEMETERY or CREMATORY <b>Greek Orthodox Cemetery</b>
24A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>	24C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6236				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6236	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>William V. Connelly</b>		2. DATE AND HOUR OF DEATH <b>June 26 1967</b> <b>2 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Little Sisters of The Poor</b> <b>1200 Valley St.</b> <b>Baltimore MD 21202</b>				A. STATE <b>MARYLAND</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		<b>10-01</b>	
				D. STREET ADDRESS (If rural, give location) <b>1200 Valley St.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <del>WIDOWED</del> , DIVORCED (specify)		B. DATE OF BIRTH <b>10/29/81</b>	9. AGE (In years last birthday) <b>85</b>	11. Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Furniture Business</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William J. Connelly</b>				14. MOTHER'S MAIDEN NAME <b>Sarah C. Kelly</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-32-2008A</b>		17. INFORMANT ADDRESS <b>Little Sisters of The Poor</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Massive myocardial infarction</b> DUE TO (B) <b>Chronic congestive heart. A.S.C.V. I</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>6/26/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1966</b> to <b>June 26 1967</b> , that (I) (we) last saw the deceased alive on <b>June 26 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Stanley Antkudas</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6/26/67.</b>	
23C. PHYSICIAN'S NAME (Type) <b>STANLEY Antkudas</b>				23D. ADDRESS <b>1101 MAIDEN CHOICE LANE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/29/67.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			



BIRTH NO. **67 6237** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 6237**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>MYRTLE ESTELLE REESE (Gemmill)</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>June 26, 1967 1:30 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5004 Ardmore Way</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore 21206</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>5004 Ardmore Way</b> D. STREET ADDRESS (If rural, give location)			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>March 20, 1896.</b>		9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Thomas L. Reese</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Weimer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-05-1526</b>		17. INFORMANT <b>Mrs. Mae Kane</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION <b>6-22-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Noturol causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/26/67</b>	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>6/29/67.</b>		23C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JUN 28 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Spitz</b>		24C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			
ADDRESS							

RECEIVED FOR FILE

*[Handwritten signature]*

Respectfully,  
[Signature]  
[Name]  
[Title]

Enclosed for [Name], [Address], [City], [State], [Zip]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6238				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 159470	
1. NAME OF DECEASED (Type or Print) <b>Edwards, Mr. John L.</b>				2. DATE AND HOUR OF DEATH <b>6/28/67 4 AM</b>		4:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>35 Church Home and Hospital Church Home &amp; Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore - Fort Howard 53-00</b> D. STREET ADDRESS (If rural, give location) <b>2 Todd Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>9/7/28</b>		9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Edwards</b>			14. MOTHER'S MAIDEN NAME <b>Lucy Adeline La Boon</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Army WWI</b>		16. SOCIAL SECURITY NO. <b>213-07-6630</b>		17. INFORMANT (Name and Address) <b>Edwards, Mrs. John L. 2 Todd Ave. Ft. Howard, Md.</b>			
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Acute M.I.</b> DUE TO (B) <b>Cerebrovascular accident, manifested</b> DUE TO <b>generalized arteriosclerotic cardiovascular disease</b> (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>6/27/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6-4</b> 19 <b>67</b> to <b>6-28</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-28</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jose Y. Ortiz</b>				23B. DATE SIGNED <b>6-28-67</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSE Y. ORTIZ</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/1/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodside Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Clover, York Co. South Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 29 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fickens</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

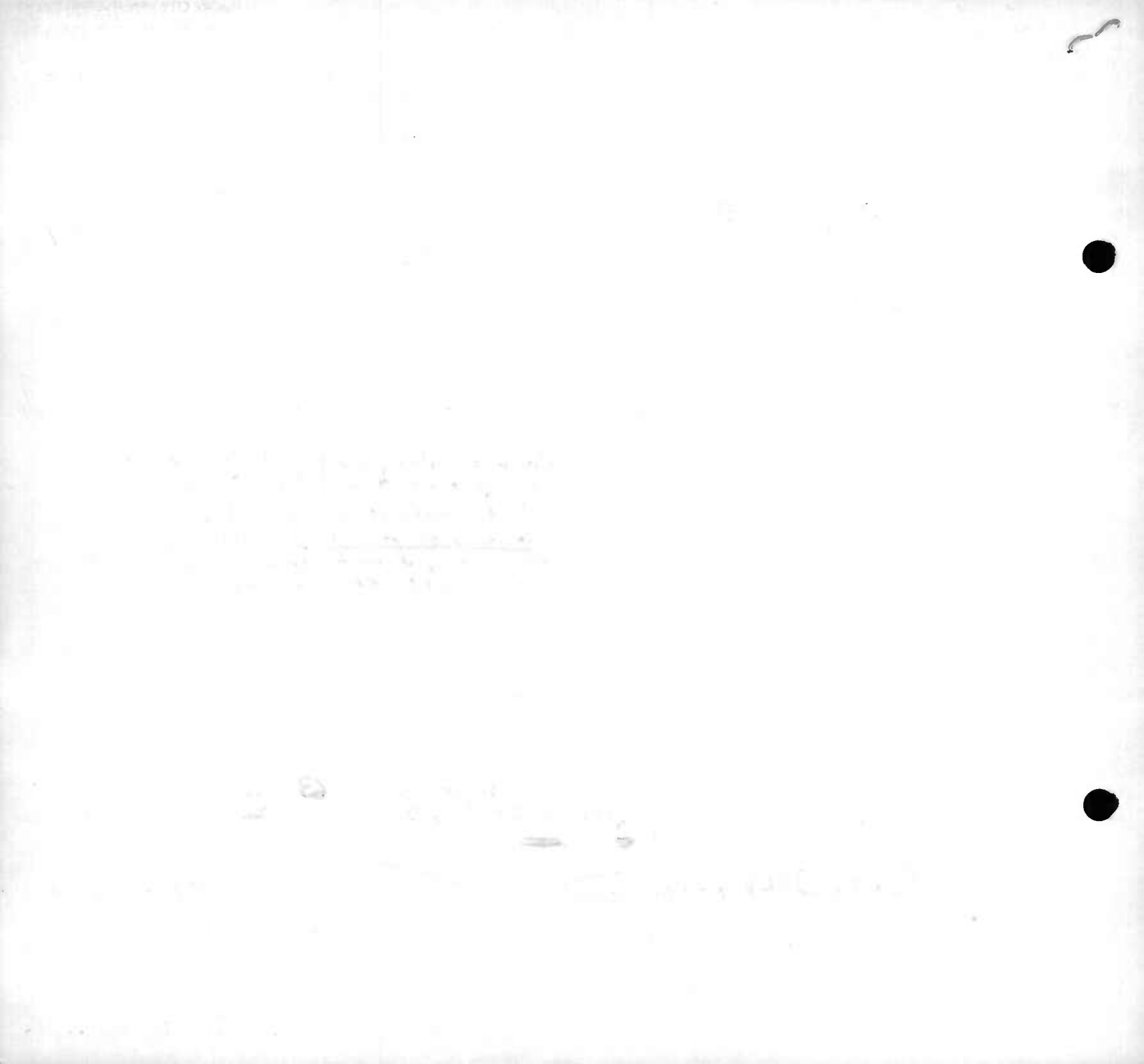
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6239		67 6239		67 6239	
M.E. CASE NO.		George W. Jaworski		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		GEORGE JAWORSKI		JUNE 27, 1967 9:05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND Baltimore		BALTIMORE - Dundalk 53-00	
FRANKLIN SQUARE HOSPITAL 36		D. STREET ADDRESS (If rural, give location)		1949 HOLBORN Rd. 21222	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	WHITE	MARRIED	OCTOBER 1, 1908	58	U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Draftsman		Bethlehem Steel Co.		WISCONSIN	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		17. INFORMANT	
GEORGE JAWORSKI		BARBARA KOZINA		WIFE, EVA JAWORSKI SAME AS DECEASED	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		392-03-7253		WIFE, EVA JAWORSKI SAME AS DECEASED	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		(A) Cerebrovascular Accident		1 Day	
ANTECEDENT CAUSES		(B) Cerebral Thrombosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Arteriosclerotic Cardiovascular Disease			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from JUNE 23 19 67 to JUNE 27 19 67, that (I) (we) last saw the deceased alive on JUNE 27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Josefina T. Naraval				June 27, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOSEFINA T. NARAVAL				FRANKLIN SQUARE HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Removal-Burial		7/1/67		Tarry Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 29 1967		John J. Duda		John J. Duda, 7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 6240				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6240	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOSEPH KOLMAN</b>				2. DATE AND HOUR OF DEATH <b>JUNE 24, 1967</b> <b>9 50 A</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 BELVEDERE NURSING HOME</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2803</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4307 FAIRVIEW AVENUE #16</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>MARCH 10, 1888</b>	9. AGE (In years lost birthday) <b>79</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF-EMPLOYED</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>GROCCER</b>		11. BIRTHPLACE (State or foreign country) <b>HUNGARY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ADOLPH KOLMAN</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>MR. MILTON KOLMAN</b>		
			ADDRESS <b>4307 FAIRVIEW AVENUE #16</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>177X I</b>				CAUSE OF DEATH (A) <b>Cardio-Respiratory Failure</b> DUE TO <b>Excessive Heart Failure</b> (B) <b>Arteriosclerotic CVD</b> DUE TO <b>Enlargement of Prostate</b> (C) <b>Generalized metastasis mainly to bone</b> <b>Terminal Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH	
II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 9</b> 19 <b>63</b> to <b>June 24</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>June 24</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Willard Applefeld</b> M.D.						23B. DATE SIGNED <b>6/25/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. WILLARD APPLEFELD</b>				23D. ADDRESS M.D. <b>5901 PARK HEIGHTS AVENUE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-26-67</b>		24C. NAME of CEMETERY or CREMATORY <b>HEBREW FRIENDSHIP</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 29 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
67 6241					67 6241				
BIRTH NO. 67 6241					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>DOLKIN, ABRAHAM</b>					2. DATE AND HOUR OF DEATH <b>6/23/67 11:00 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY OF Maryland Hospital</b> <b>Lombard &amp; Greene St.</b> <b>Balto. 21201 MD</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>				
D. STREET ADDRESS (If rural, give location) <b>2805 Hilldale Avenue</b>									
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>6/18/1967</b>	9. AGE (In years, lost birthday) <b>67</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WORKSHOP FOR BLIND</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>DOLKIN, HARRIS</b>					14. MOTHER'S MAIDEN NAME <b>SARAH WOLCOFF</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>220-57-8958</b>		17. INFORMANT <b>CHART</b>			ADDRESS	
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Core Hemorrhage</b>					<b>2 days</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma of stomach</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>6/18/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>6/18/67</b> to <b>6/23/67</b> , that (1) (we) lost the deceased alive on <b>6/23/67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Irvin M. Sopher MD</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6/23/67</b>		
23C. PHYSICIAN'S NAME (Type) <b>IRVIN M. SOPHER</b>					23D. ADDRESS <b>UNIVERSITY of Md. Hospital, Balto.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/26/67</b>		24C. NAME of CEMETERY or CREMATORY <b>BETH JACOB (VECAIR)</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 29 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, MD</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST, RD.</b>			ADDRESS		

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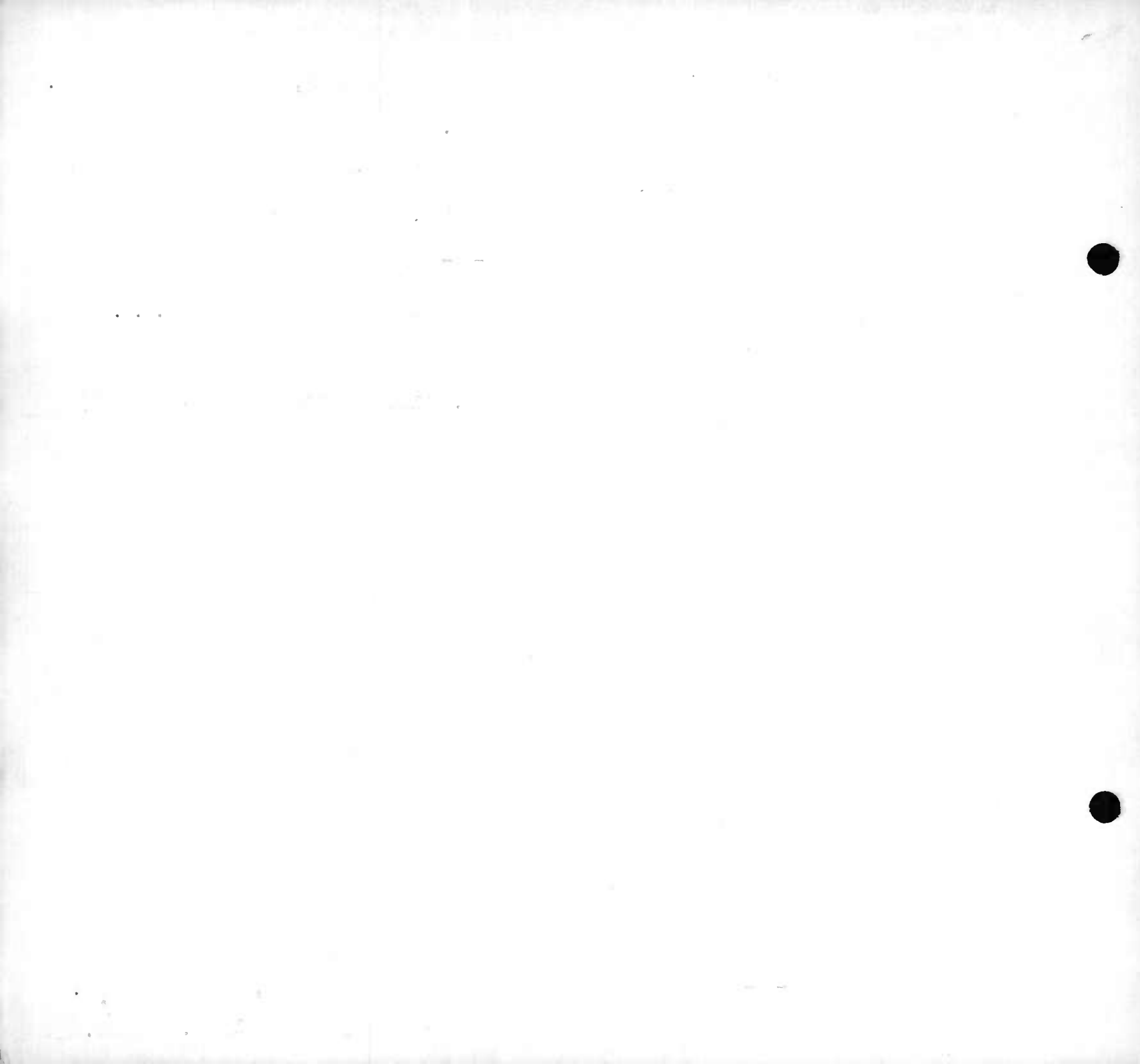
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6242				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6242			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Anna Marie Durkin				2. DATE AND HOUR OF DEATH June 27, 1967 6 a. m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 23-03							
FULL NAME OF HOSPITAL OR INSTITUTION 00 3 West Barney Street				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 3 West Barney Street			
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 6-15-1903		9. AGE (In years lost birthday) 64		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George VonCulin				14. MOTHER'S MAIDEN NAME Mary Shook							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. William Durkin		ADDRESS (same as # 4)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 15-4X I CAUSE OF DEATH (A) DUE TO Carcinoma of Rectum 9 mos. (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 19-55 to June 26 1967 that (I) (we) lost saw the deceased alive on June 26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Halter Kohn				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/27/67					
23C. PHYSICIAN'S NAME (Type) WALTER KOHN		23D. ADDRESS 102 E FORT AVE									
24A. BURIAL CREATION, REMOVAL (Specify) Burial		24B. DATE 6-30-1967		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1967		25B. NAME OF REGISTRAR R. E. T. T. T.		25C. FUNERAL DIRECTOR McCully Funeral Home		ADDRESS 130 E. Fort Ave. #30					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

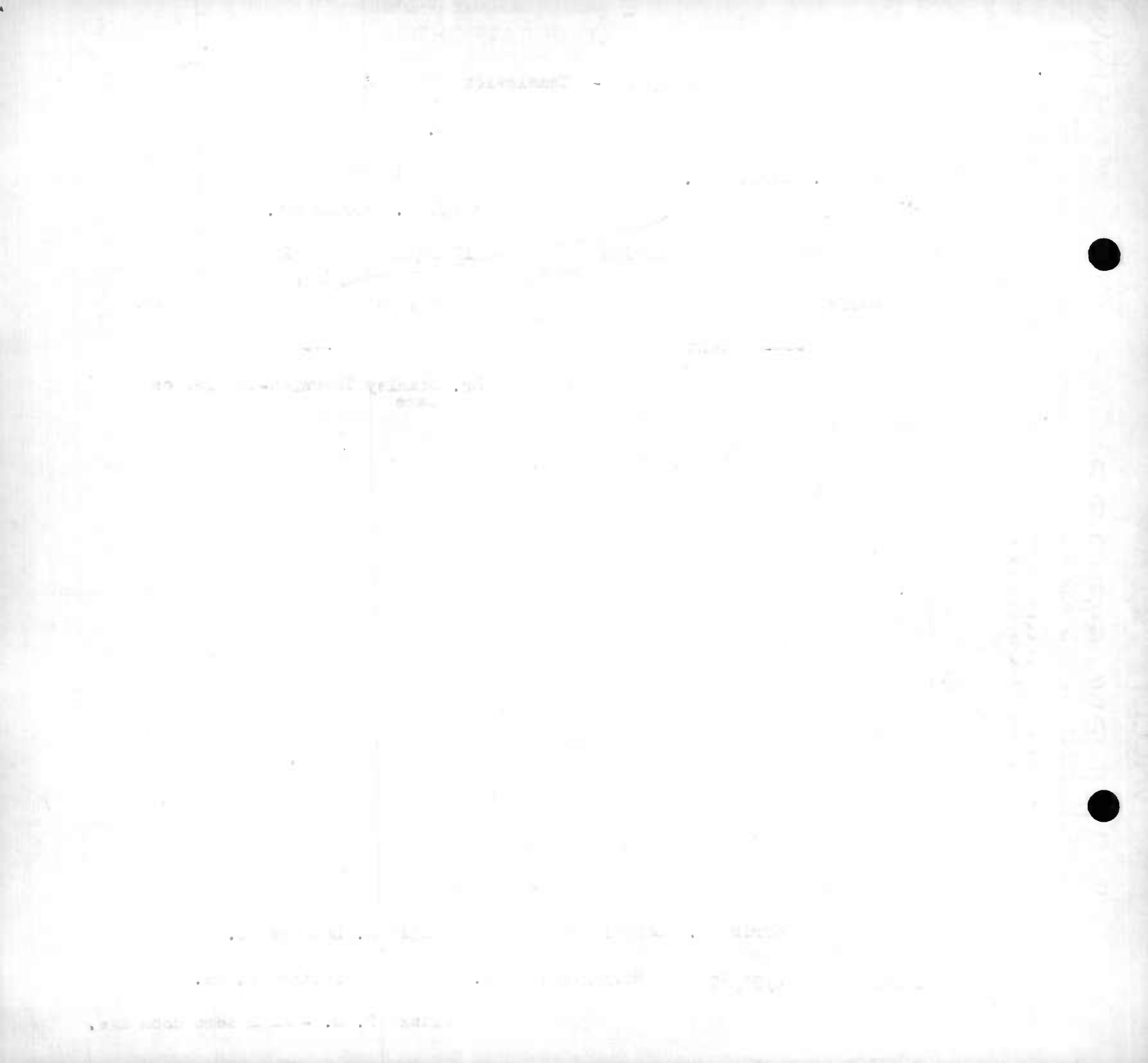
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6243</b>	
BIRTH NO. <b>67 6243</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ESTHER KRAVITZ</b>		2. DATE AND HOUR OF DEATH <b>6/25/67 9:45 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>15-38</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>3605 LIBERTY HTS. AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WID</b>	8. DATE OF BIRTH <b>2/24/93</b>	9. AGE (In years lost birthday) <b>74</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
13. FATHER'S NAME <b>BORACH</b>		14. MOTHER'S MAIDEN NAME <b>TOBA ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.-A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-38-3473</b>		17. INFORMANT <b>HOSPITAL CHART</b>	
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CHROBROVASCULAR ACCIDENT</b> II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 DA.</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/21</b> 19 <b>67</b> to <b>6/25</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/25</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sheldon Frank</b>				23B. DATE SIGNED <b>6/25/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>SHELDON FRANK</b>		23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/27/67</b>		24C. NAME of CEMETERY or CREMATORY <b>HEBREW YOUNG MEN</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 29 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6244</b>	
BIRTH NO. <b>67 6244</b>				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>Melvina Tomavich - Tomalavicz</b>			2. DATE AND HOUR OF DEATH <b>6-26-67 7 P M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>437 S. Parrish St.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>19-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>437 S. Parrish St.</b>		
5. SEX <b>F</b>	6. RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12/10/84</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Poland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>--- Vent</b>		
14. MOTHER'S MAIDEN NAME <b>---</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mr. Stanley Tomavich-Tomalavicz</b> Same		
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Heart Disease</b>			CAUSE OF DEATH (A) <b>Arteriosclerotic Heart Disease</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> to <b>June 26 1967</b> , that (I) (we) last saw the deceased alive on <b>June 23 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Morris B. Schreiber</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>6-27-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Morris B. Schreiber</b>				23D. ADDRESS <b>1519 W. Lombard St.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/29/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 29 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Schreiber</b>		25C. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Ave.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6245

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RALPH

QUINTRELL

2. DATE AND HOUR PRONOUNCED DEAD

June 27, 1967

6:32 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
HOSPITAL OR ADDRESS OR LOCATION)  
INSTITUTION

3801 Stokes Drive

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3801 Stokes Drive

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

B. DATE OF BIRTH

6/18/01

9. AGE (In years  
last birthday)  
66If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tenn.

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

James Quintrell

14. MOTHER'S MAIDEN NAME

Mary Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
401-01-3511

17. INFORMANT

Mrs. Ralph Quintrell  
3801 Stokes Dr. - 21229

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/27/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/29/67

23C. NAME of CEMETERY or CREMATORY

Lorraine Park Cem.

23D. LOCATION

(City, town, or county)

Balto., Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 29 1967

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

Witzke F. D. - 4101 Edmondson Ave.

ADDRESS

1104

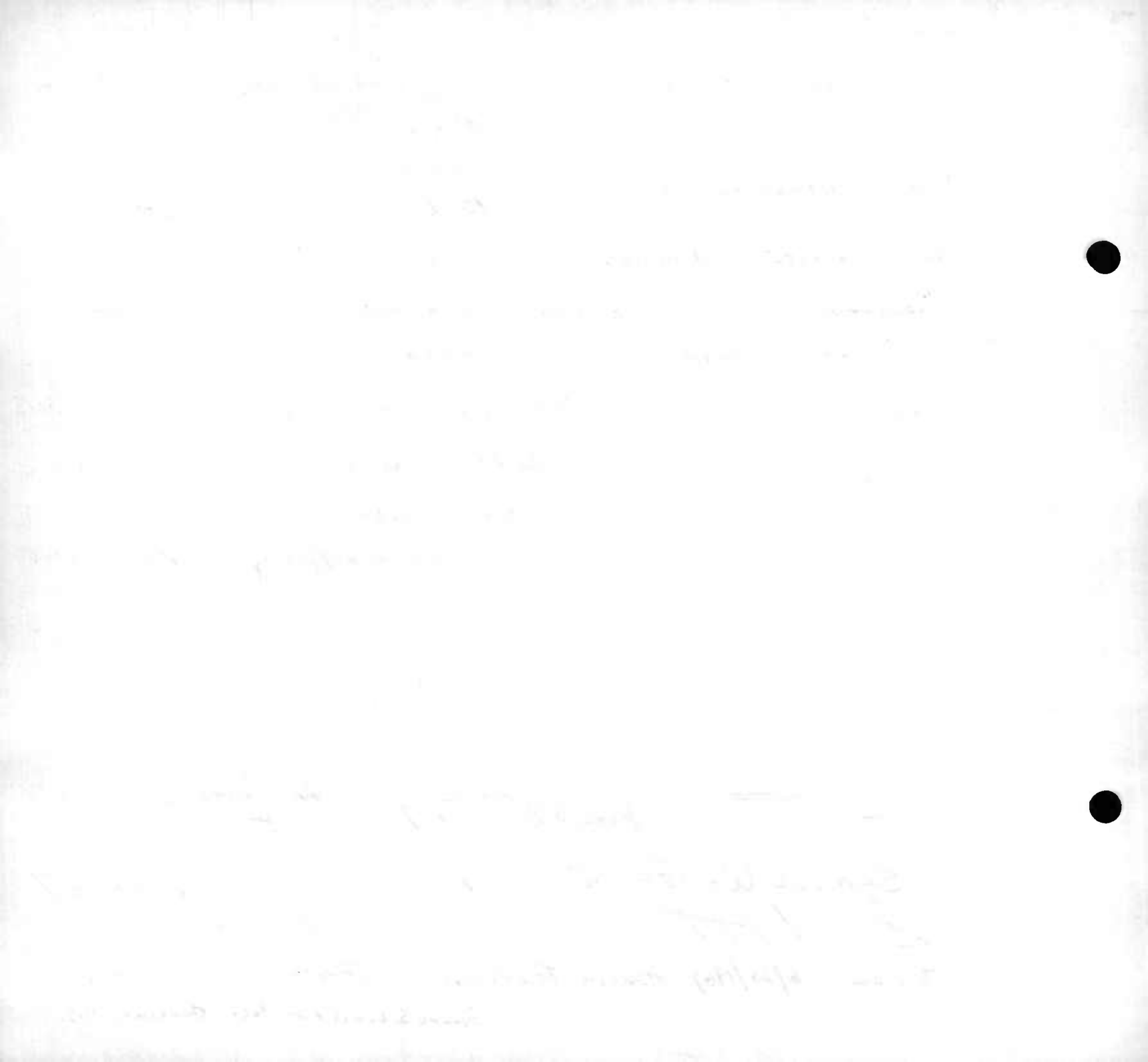
12152 • J. Neurosci., September 24, 2008 • 28(39):12147–12152



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6246				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6246	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>ISADORE A. STEIN</i>		2. DATE AND HOUR OF DEATH <i>JUNE 27, 1967</i> 8 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>44 UNION MEMORIAL HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Balt. Co</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> 53-00 D. STREET ADDRESS (If rural, give location) <i>1326 CHURCH HILL DRIVE</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>JULY 4, 1895</i>	9. AGE (In years last birthday) <i>71</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>MICHAEL STEIN</i>			14. MOTHER'S MAIDEN NAME <i>ROSA</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>215-01-1939A</i>			17. INFORMANT <i>MRS YETTA STEIN 1326 CHURCH HILL DRIVE</i>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>acute myocardial infarction</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>coronary sclerosis</i> <i>murmured in suffering</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Two hours</i> <i>1950</i> <i>March 1967</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>June 1946</i> to <i>June 27, 1967</i> , that (I) (we) last saw the deceased alive on <i>June 27, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>SAMUEL WHITEHOUSE</i> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/28/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Samuel Whitehouse</i>				23D. ADDRESS M.D. <i>3901 IV Chores St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6/28/1967</i>		24C. NAME OF CEMETERY or CREMATORY <i>HEBREW FRIENDSHIP</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO. MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 29 1967</i>		25B. NAME OF REGISTRAR <i>R. E. L. L. L.</i>		25C. FUNERAL DIRECTOR <i>SYLVAN S. LEWIS &amp; SON, INC.</i>		ADDRESS <i>GARRISON, MD.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6247</b>	
BIRTH NO. <b>67 6247</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MRS. AGNES TOLSON (Agnes Katherine Tolson)</b>		2. DATE AND HOUR OF DEATH <b>6-27-67 8 25 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSPITAL</b> <b>100 N. BROADWAY, BALTIMORE - 21231</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
<b>BALTIMORE</b>		<b>243 Ballou Ct. 21231</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>5-5-85</b>	9. AGE (In years last birthday) <b>82</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>John Weggel</b>		14. MOTHER'S MAIDEN NAME <b>XXXXXXXXXXXXXXXXXXXX Anna ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-09-6901</b>		17. INFORMANT <b>FROM ADMITTING CHART</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis, left</b> <b>CEREBROVASCULAR ACCIDENT</b>		CAUSE OF DEATH <b>CEREBROVASCULAR ACCIDENT</b>		INTERVAL BETWEEN ONSET AND DEATH <b>year</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b>		(B) DUE TO <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b>		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>-</b>					
19A. DATE OF OPERATION <b>5-25-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TRACHEOSTOMY</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-18-67</b> to <b>6-27-67</b> , that (I) (we) last saw the deceased alive on <b>6-27-67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>6-27-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. A. C. Saperstein</b>				23D. ADDRESS <b>Church Home &amp; Hosp.</b>	
24A. BURIAL-CREATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/1/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill</b>	
24D. LOCATION (City, town, or county) (State) <b>Ritchie Hyway A. A. Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 29 1967</b>			
25B. NAME OF REGISTRAR <b>A. E. Saperstein</b>		25C. FUNERAL DIRECTOR <b>McCully Funeral Home</b>			
25D. ADDRESS <b>Patapsco Ave. at 3rd St. Brklyn</b>					

1947 EAGLE CO. 1111  
2-2-22

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MILLIE ANN SWITZER

2. DATE AND HOUR PRONOUNCED DEAD

6-27-67 6:35 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

23 S. Carey Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

DIVORCE

8. DATE OF BIRTH

10-6-1921

9. AGE (In years  
last birthday)

44 45

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home Restaurant - Waitress

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Hugh G. Bryant

14. MOTHER'S MAIDEN NAME

Lucy J. Fitzgerald

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO NO

16. SOCIAL  
SECURITY NO.

212-26-4422

17. INFORMANT

Mrs Wm Phillips Ritz-STANTON VA

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Russell S. Fisher

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-28-67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

6/30/67

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cem

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 29 1967

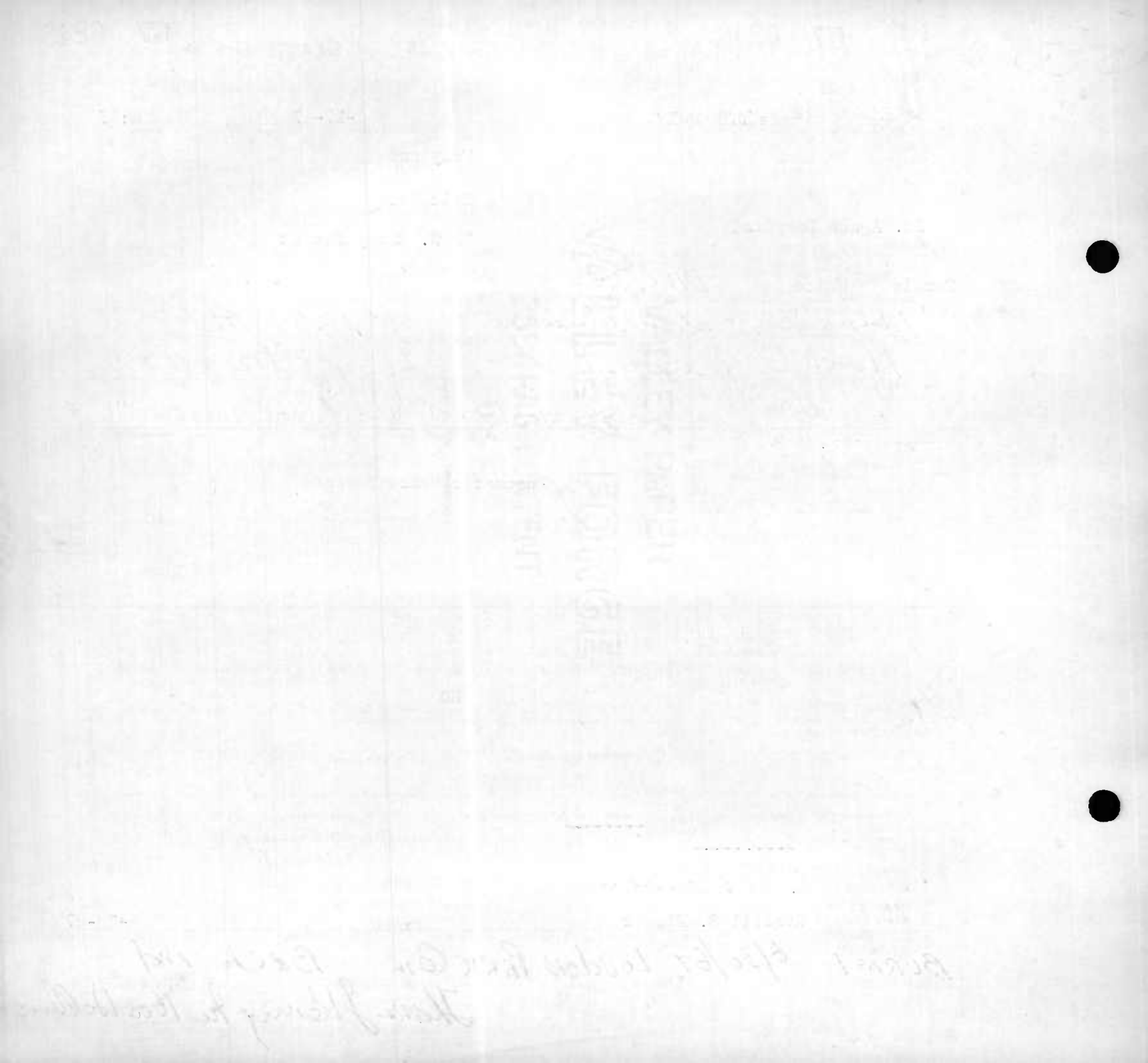
24B. NAME OF REGISTRAR

Robert E. Tabor

24C. FUNERAL DIRECTOR

Thomas J. Konyak 1600 Hollins

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 6249	
BIRTH NO. 67 6249		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>EDWARD L. PARKER SR</b>		2. DATE AND HOUR OF DEATH <b>6-21-67</b> <b>L:05 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1-03</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>5525 FAIT Ave.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>5525 FAIT Ave</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>5-1-12</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Binder OPER.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>C.C. &amp; S.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>VINCENT PARKER</b>			12. CITIZEN OF WHAT COUNTRY?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. A. PARKER</b>
					ADDRESS <b>SAME</b>
18. <b>420.01</b>		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>Coronary Heart Disease</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>June 16</b> 19 <b>67</b> to <b>June 21</b> 19 <b>67</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>June 16</b> 19 <b>67</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Clarence W. LeDoux</b> M.D.				23B. DATE SIGNED <b>6/21/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Clarence W. LeDoux</b> M.D.				23D. ADDRESS <b>3023 Eastern Ave. Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-24-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY ROSARY</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore Ch. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 29 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR <b>Raymond L. Kaczorowski</b>	
				ADDRESS <b>5525 FAIT ST #19</b>	

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

11. 12. 13. 14. 15. 16. 17. 18. 19. 20.

21. 22. 23. 24. 25. 26. 27. 28. 29. 30.

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41. 42. 43. 44. 45. 46. 47. 48. 49. 50.

51. 52. 53. 54. 55. 56. 57. 58. 59. 60.

61. 62. 63. 64. 65. 66. 67. 68. 69. 70.

71. 72. 73. 74. 75. 76. 77. 78. 79. 80.

81. 82. 83. 84. 85. 86. 87. 88. 89. 90.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6250</b>	
BIRTH NO. <b>67 6250</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Mr. Joseph Jackson</b>		2. DATE AND HOUR OF DEATH <b>6/27/67 10:04 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>9-07</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>2529 Aisquith Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8/9/08</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Richard Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Sara</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes W W 2</b>		16. SOCIAL SECURITY NO. <b>577-18-3043</b>		17. INFORMANT <b>Mrs Leola Jackson Same</b>	
18. <b>491X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Bacterial bronchopneumonia 4-5 days</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(at)</del> (this hospital) attended the deceased from <b>6/26</b> 19 <b>67</b> to <b>6/27</b> 19 <b>67</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>6/27</b> 19 <b>67</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Nat E. Watson Jr.</b>				23B. DATE SIGNED <b>6/27/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. NAT E. WATSON</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/3/67</b>		24C. NAME of CEMETERY or CREMATORY <b>National Cemetry</b>	
24D. LOCATION <b>Baltimore Md</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JUN 29 1967</b>		24F. NAME OF REGISTRAR <b>Robert E. Faldy</b>	
24G. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		24H. ADDRESS <b>1206 W North Ave</b>			

1111 Jackson Avenue

Union Memorial Hospital

Male Negro Married

Richard Jackson

2224 Washington Street

8/9/08 28

South Carolina

2014

Mrs. Leola Jackson Same

02 - 0/02

0/02 - 0/02

0/02

+

Walt Jackson Jr.

BIRTH NO. 87 6251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67. 6251M.E. CASE NO. 64-204401. NAME OF DECEASED  
(Type or Print)

INEZ

MITCHELL

2. DATE AND HOUR PRONOUNCED DEAD

June 27, 1967

2:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1003 Rutland Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1003 Rutland Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9-25-1966

9. AGE (In years  
last birthday)

9 mos.

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Baby

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Mitchell Jr.

14. MOTHER'S MAIDEN NAME

VIVIAN JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no.

16. SOCIAL  
SECURITY NO.

17. INFORMANT

VIVIAN MITCHELL

ADDRESS

1003 Rutland Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Hanging  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1003 Rutland Avenue

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) June 27, '67

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Fell throughside of  
crib - suspended on neck - feet above  
ground.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/27/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/30/67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

(State)

AA, County, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 29 1967

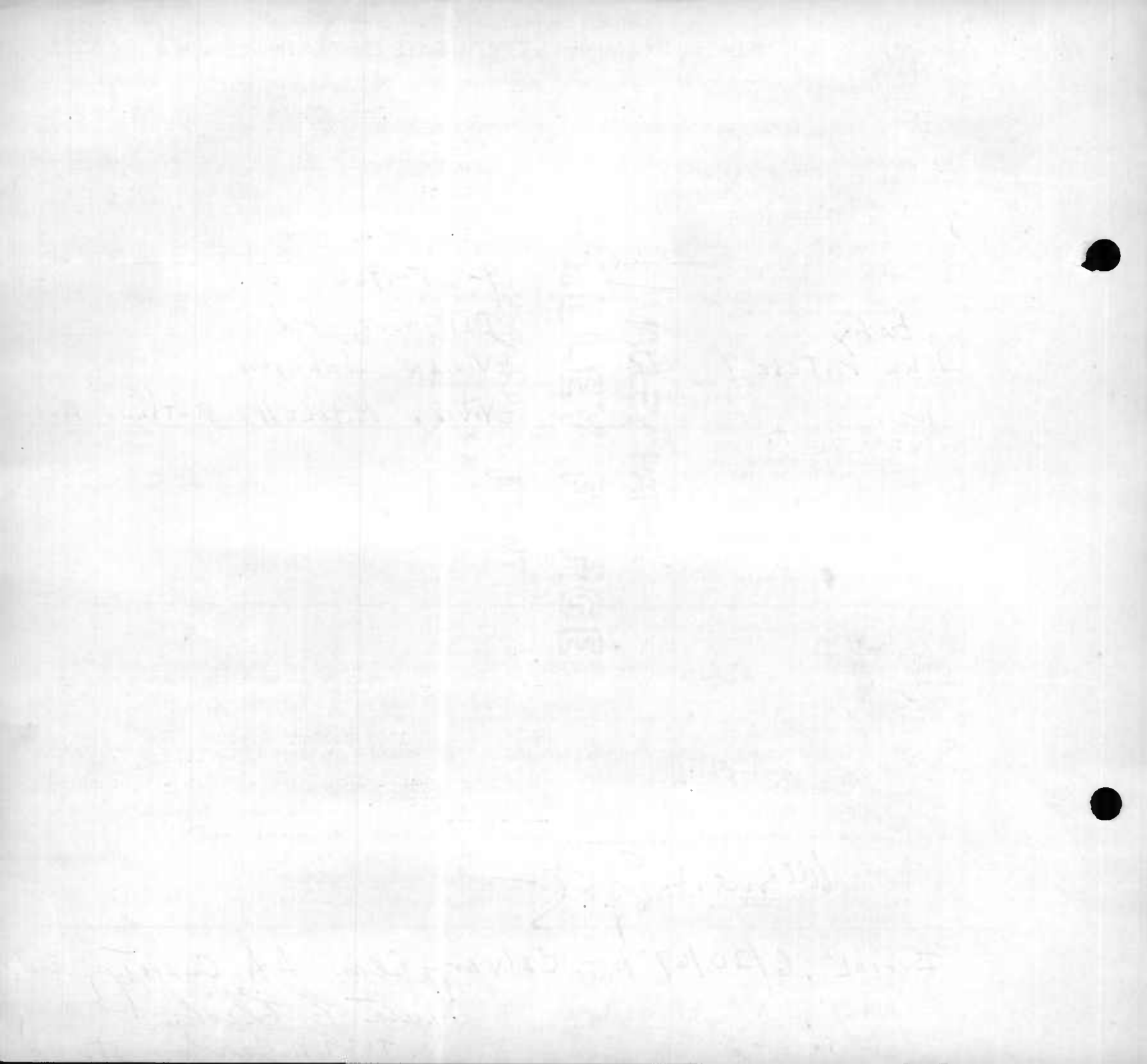
24B. NAME OF REGISTRAR

Robert E. Fadden

24C. FUNERAL DIRECTOR

Milton E. Elickson

ADDRESS



BIRTH NO. **67 6252** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 6252**

M.E. CASE NO.

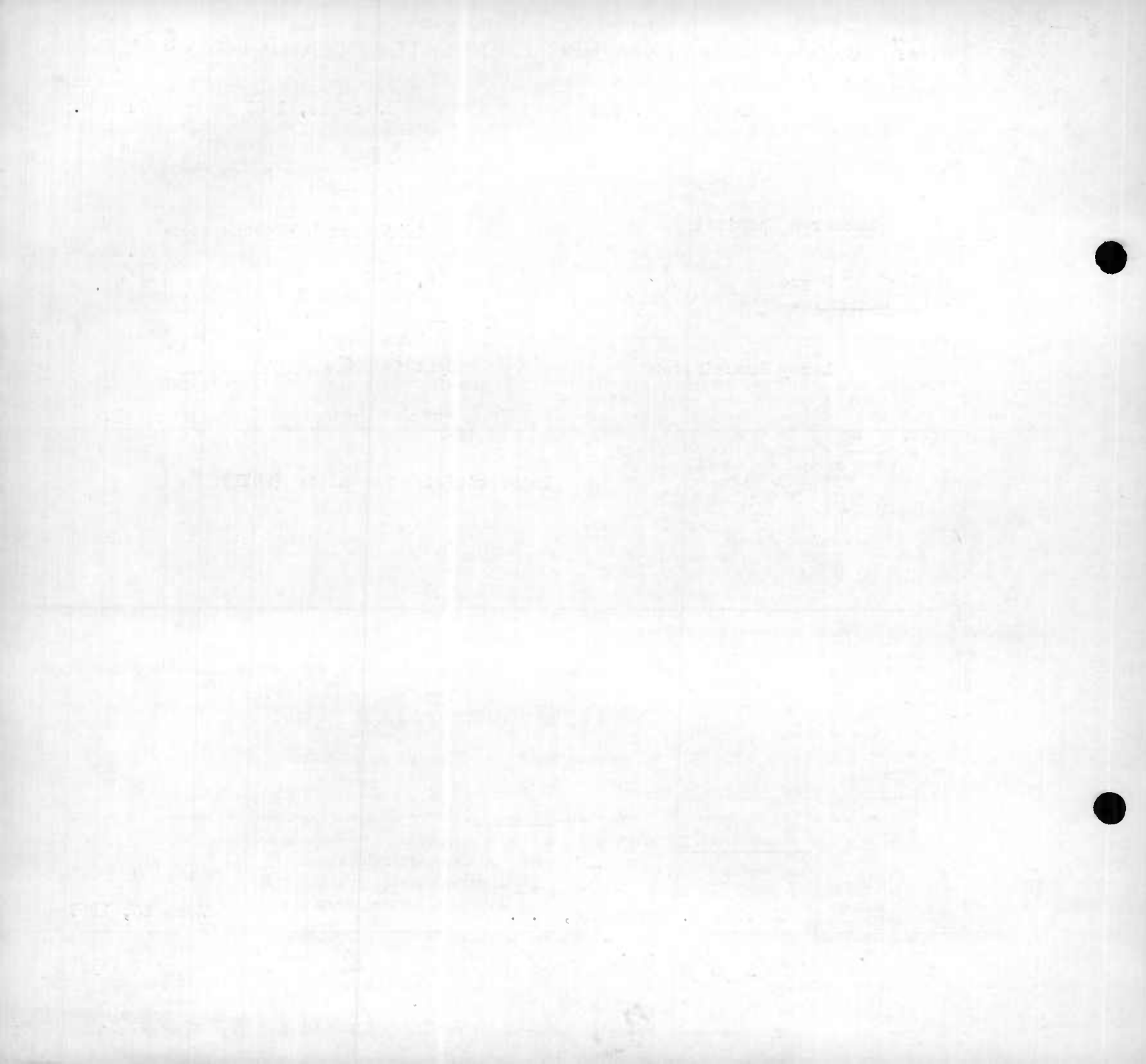
1. NAME OF DECEASED (Type or Print) <b>ALFRED S. BOYD</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>6-25-67 2:20 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>PROVIDENT HOSPITAL - DOA</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>20-02</b> D. STREET ADDRESS (If rural, give location) <b>21 Calverton Road 21223</b>			
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Separated</b>	8. DATE OF BIRTH <b>3/18/1945</b>	9. AGE (In years last birthday) <b>22</b>	If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Norman Boyd</b>			14. MOTHER'S MAIDEN NAME <b>Alice Lane</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>212-44-2174</b>			17. INFORMANT <b>Alice Boyd</b>		ADDRESS <b>Same</b>		
18. <b>E982X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Stab wound of chest</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) DUE TO			
(B) DUE TO				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2400 Callow Avenue 13-01</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>6 25 '67 1:30 PM</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Stabbed during altercation</b>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>6/29/67</b>		23C. NAME of CEMETERY or CREMATORY <b>Carver Mem. Pl. Laurel Md.</b>		23D. LOCATION (City, town, or county) (State) <b>MD.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JUN 29 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		24C. FUNERAL DIRECTOR <b>Washington &amp; Phillips</b>		ADDRESS <b>1727 N. Mount St.</b>	

3/18/1942  
Lafayette  
Rustic  
Black  
White

6/20/1942  
Lafayette  
Rustic  
Black  
White

BIRTH NO. **67 6253** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 6253**M.E. CASE NO. **67-10275**

1. NAME OF DECEASED (Type or Print)		RODNEY JONES		2. DATE AND HOUR PRONOUNCED DEAD June 18, 1967		7:00 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b>				A. STATE <b>Maryland</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>1635 West LaFayette Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>May 26, 1967</b>	9. AGE (In years lost birthday) <b>3 yrs.</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. <b>3 wks.</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Leroy Brockington</b>				14. MOTHER'S MAIDEN NAME <b>Cynthia Robinson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Cynthia Jones</b>		ADDRESS <b>Same</b>	
18. <b>763X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>INTERSTITIAL PNEUMONITIS (SDII)</b>				CAUSE OF DEATH (A) <b>INTERSTITIAL PNEUMONITIS (SDII)</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
(C) DUE TO							
ii OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Springate</b>		M.D. <b>Charles S. Springate</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>June 18, 1967</b>	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>6/23/67</b>		23C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JUN 29 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		24C. FUNERAL DIRECTOR <b>Arlington S. Phillips</b>		ADDRESS <b>1727 N. Monmouth</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6254				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6254	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				FIRE GAUGH, MINNIE		6/27/67 6 10 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
44 UNION MEMORIAL HOSPITAL				MD 21204		Balt. Co.	
5. SEX F				6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
				—		10/23/81	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
ROBERT SHIFLET				UNKNOWN		25	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				213-05-9634D		MRS Virginia Weber	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)				(A) CARCINOMA		UNKNOWN	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
6/22/67		RESECTION OF NEURAL COLONOSTOMY		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6/22 1967 to 6/27 1967, that (I) (we) last saw the deceased alive on 6/27 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Sigrid A. Heine				6/27/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ALBERT A. MONTAGUE				THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL				6-29-67		MEADOW RIDGE	
25A. DATE OF REGISTRATION				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 29 1967				Robert E. Taylor		Wm Cook-Brooks Towson	
25D. LOCATION (City, town, or county)				25E. ADDRESS			
Dorsey - Howard Co. Md.				10504 OKK RD		Towson Md	

14018 07

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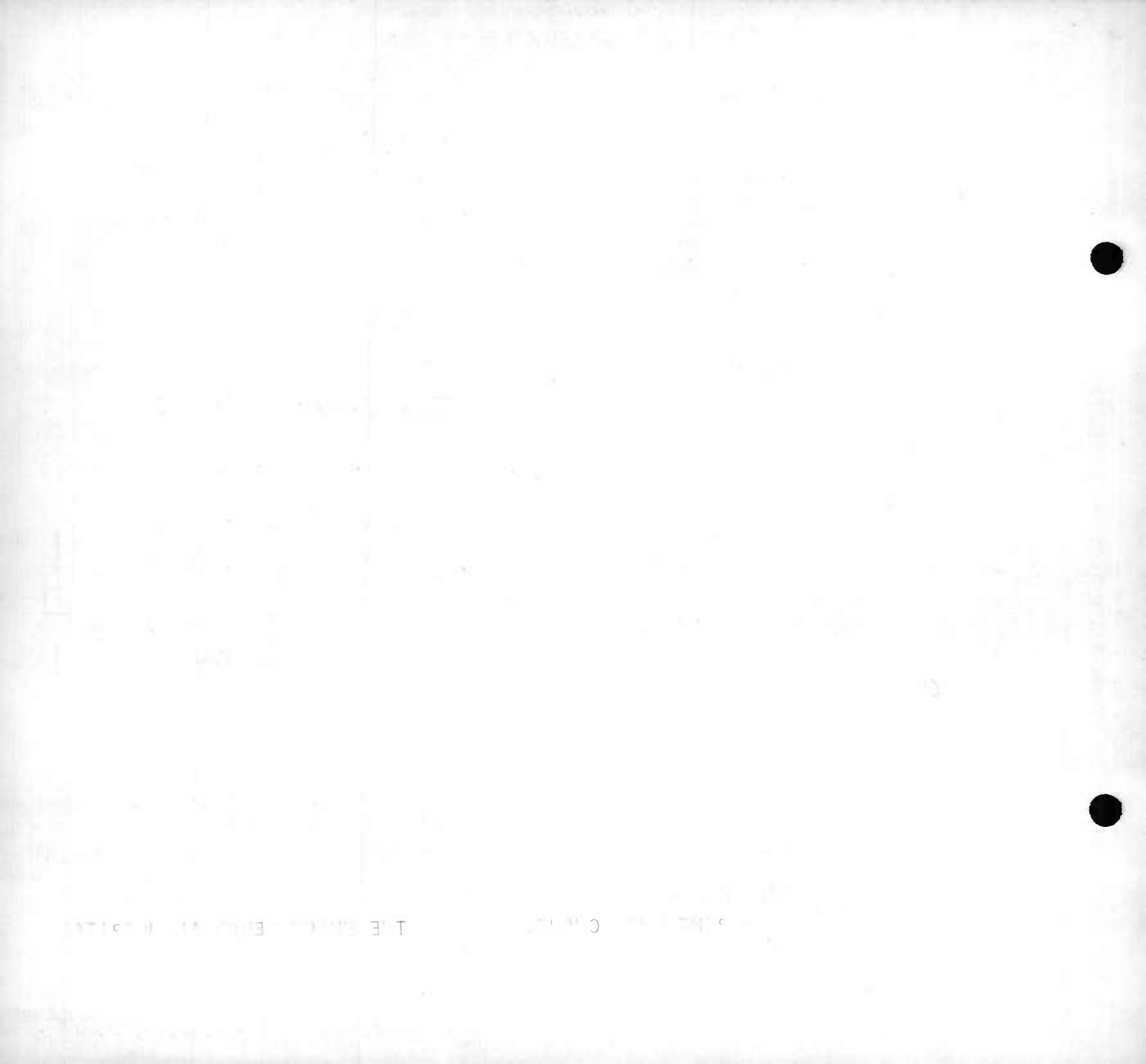
14018 07

14018 07

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6255</u>	
BIRTH NO. <u>65-17497</u>		67 6255		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>TOSH, SHIRLEY ANN</u>		2. DATE AND HOUR OF DEATH <u>JUNE 28, 1967</u> <u>5:55</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE UNION MEMORIAL HOSPITAL</u> <u>33RD AND CALVERT ST., BALTIMORE, MD.</u>		A. STATE <u>MARYLAND</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
		B. COUNTY		D. STREET ADDRESS (If rural, give location) <u>2001 EAST 30TH STREET</u>	
5. SEX <u>F</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>JULY 15, '65</u>	9. AGE (In years, last birthday) <u>2</u> <u>yo.</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>WILLIAM J. TOSH</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH BOOTH</u>		17. INFORMANT ADDRESS <u>W.J. TOSH 2001 E. 30TH ST.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CONGENITAL BILIARY ATRESIA SINCE BIRTH</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>CONGENITAL BILIARY ATRESIA</u> DUE TO			
		(B) <u>SECONDARY BILIARY CIRRHOSIS</u> DUE TO			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JUNE 24, 1967</u> to <u>JUNE 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>JUNE 28, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Pong Moon Chang</u>				23B. DATE SIGNED <u>6/28/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>BORN W. NILSON</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/30/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>MEADOWRIDGE CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>					
25A. DATE REC'D BY HEALTH/DEPT. <u>JUN 29 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>B. DABROW 1254 E. BALTO. ST.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6256				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6256	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				LENA G. GORDON		JUNE 25, 1967 1:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
4541 PIMLICO ROAD						MARYLAND 27-16	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
BALTIMORE				4541 PIMLICO ROAD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
F	W	WIDOW	3/18/1879	88			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
NONE					LITHUANIA		U.S.A
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ISADORE				JEANETTE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				NONE		IRVING GORDON - 6103 STUART AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		Myocardial Infarction, Acute minutes	
ANTECEDENT CAUSES				(B) DUE TO		ASCVD 30 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 19 52 to JUNE 25 19 67, that (I) (we) last saw the deceased alive on JUNE 23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Harvey S. Feuerman						6/25/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Harvey S. Feuerman				6210 Park Heights Ave, Baltimore Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or County) (State)	
Burial		6/27/67		B'nai Israel		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 29 1967		Robert E. Taylor, M.D.		Sydney S. Lewis & Son, Inc.		Garrison Md	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6257</b>	
BIRTH NO. <b>67 6257</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Nichols - Mrs Nora E.</b>		2. DATE AND HOUR OF DEATH <b>6/26/67 - 2:25PM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hosp.</b> <b>34</b>		A. STATE <b>MD.</b> B. COUNTY <b>19-04</b> C. CITY, OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE, Md.</b> D. STREET ADDRESS (If rural, give location) <b>230 S. Mount St.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>12/28/1891</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cleaning Lady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bank Building</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co. Md.</b>	
13. FATHER'S NAME <b>Samuel Burroughs</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT (21224) Md. <b>Mrs. Helen W. Delaco 712 S. 49th. St. Balto.</b>	
18. <b>5-70.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Intestinal Obstruction</b> DUE TO (B) <b>Uremia</b> DUE TO (C) <b>Renal Shutdown</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6-16</b> 19 <b>67</b> to <b>6-26</b> 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6-26</b> 19 <b>67</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Milagros L. Guerrero</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>6/26/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>MILAGROS L. GUERRERO</b>		23D. ADDRESS <b>Bon Secours Hosp -</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 29, 1967</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 29 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>G. Truman Schwab 3512 Frederick Ave. Balto. Md.</b>			





67 6258

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6258

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LAWRENCE JEROME

SCHULTZ

2. DATE AND HOUR PRONOUNCED DEAD

June 20, 1967

7:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

100 1012 Hollins Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1012 Hollins Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

MARCH 15, 1898

9. AGE (In years  
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HUSBAND

10B. KIND OF BUSINESS OR INDUSTRY

PRODUCE

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

FREDERICK SCHULTZ

14. MOTHER'S MAIDEN NAME

LOUISE WHITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWI

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

LORETTA SCHULTZ 1401 KENT AVE.

18.

5810 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Fatty Alteration of Liver

(A).....  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B).....  
DUE TO

(C).....

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/19/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

6-28-1967

23C. NAME OF CEMETERY or CREMATORY

BALTIMORE NATIONAL

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

JUN 29 1967

24B. NAME OF REGISTRAR

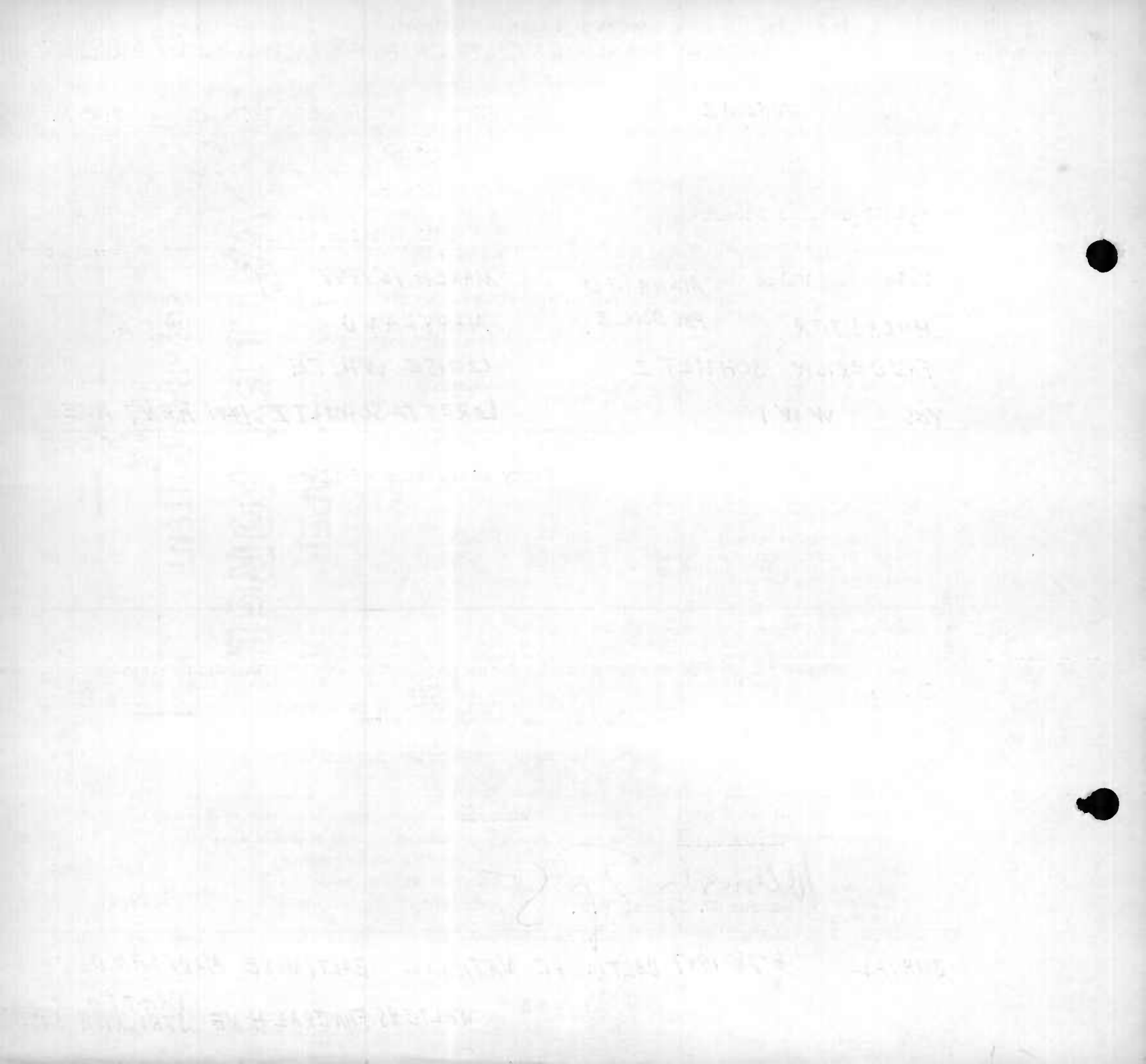
Robert E. Feltman

24C. FUNERAL DIRECTOR

WALTERS FUNERAL HOME

ADDRESS

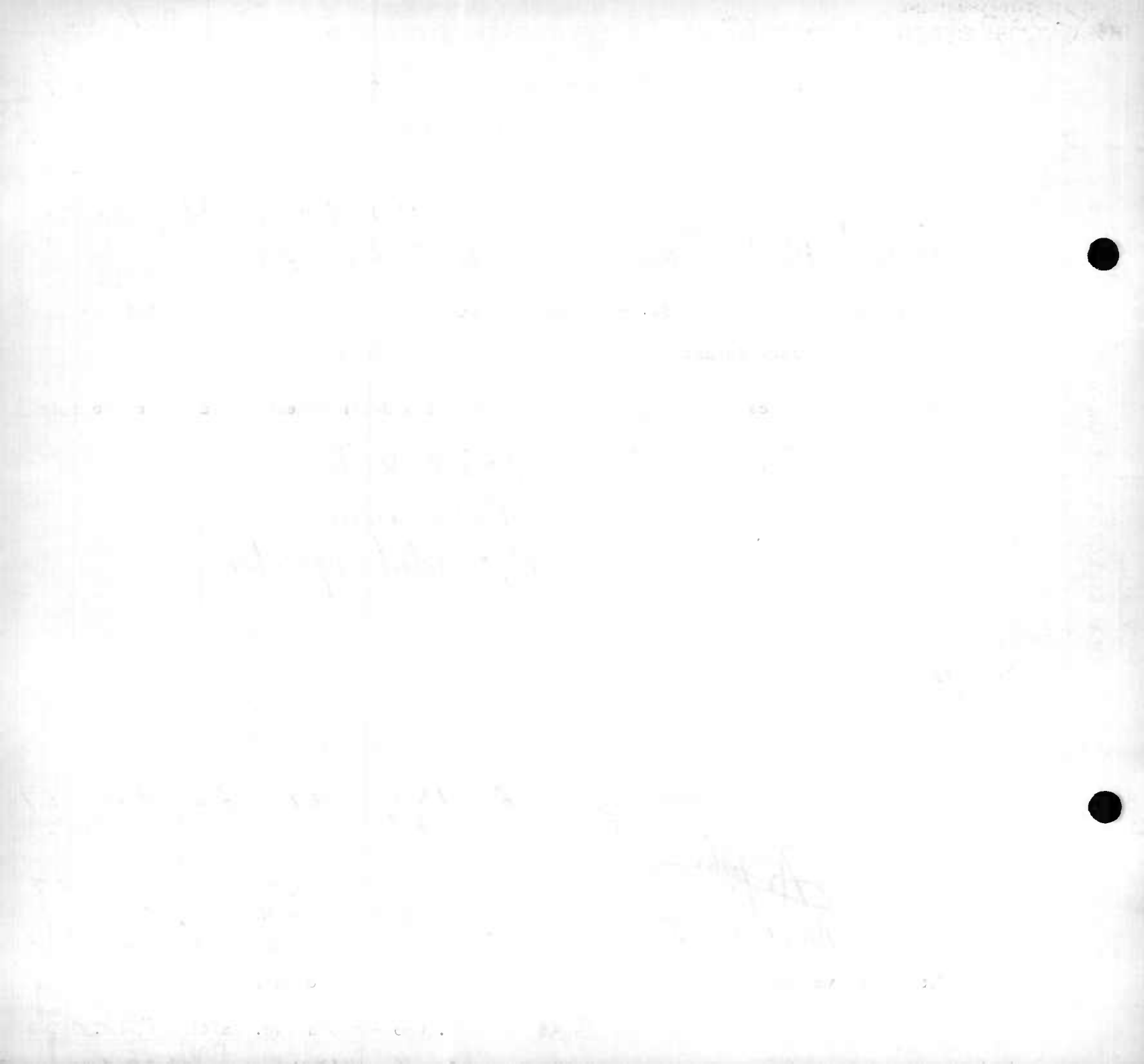
PRATT &  
STRICKER STS.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6259		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6259	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>KNIGHT JAMES W</b>		
2. DATE AND HOUR OF DEATH <b>6-28-67 12-25 P.M.</b>			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>A.A. Co</b>			5. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 52-00</b>		
6. STREET ADDRESS (If rural, give location) <b>5409 Maggie St (MAGIE)</b>			7. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Lutheran Hospital of Maryland 46</b>		
5. SEX <b>Male</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12-9-1897</b>	9. AGE (In years lost birthday) <b>69</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Jack Knight</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>WW 1 Yes</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Harris &amp; Smith Funeral Home McRae, Georgia</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>A.S.C.V.D.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pneumonia</b> <b>Myocardial infarction</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6-20-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-13-1967</b> to <b>6-28-1967</b> , that (I) (we) last saw the deceased alive on <b>6-28-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anjosh</b>			23B. DATE SIGNED <b>6-28-67</b>		
23C. PHYSICIAN'S NAME (Type) <b>ANIL M. JOSHI</b>			23D. ADDRESS <b>Lutheran Hospital of Maryland 730 Ashburton St Baltimore 21216</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>6/29/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>McRae Georgia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 29 1967</b>		25B. NAME OF REGISTRAR <b>R. E. Edwards</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</b>	



FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6260</b>	
BIRTH NO. <b>67 6260</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Allen Washington</b>		2. DATE AND HOUR OF DEATH <b>June 24, 1967 10:55 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore,</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>14-02</b> D. STREET ADDRESS (If rural, give location) <b>1426 Argyle Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>3-8-19</b>	9. AGE (In years last birthday) <b>48 yrs.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>William Banks - Friend 1330 Druid Hill Ave</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <b>HASCVD; Possible M.I.</b> DUE TO (B) <b>CVA</b> DUE TO (C) <b>Chronic bronchitis &amp; aspietic pneumonitis</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 18, 19 67</b> to <b>June 24, 19 67</b> , that (I) (we) last saw the deceased alive on <b>June 24, 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>LizaraZO</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-26-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>LIZARAZO</b>		23D. ADDRESS M.D. <b>1514 Division Street Balto., Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-3-67</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore. Maryland</b>	
25A. DATE RECD BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>R. E. E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>A. Halstead. 1206 W. North Ave.</b>	

15 AR 20  
15 AR 20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6261				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6261	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Walter F. Thompson</b>			
2. DATE AND HOUR OF DEATH <b>June 28, 1967 1:25 P.</b>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 5837 Belair Rd. House In Pines Nursing Home</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>23-02</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>54 E. Heath St.</b>				5. SEX <b>Male</b>			
6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>8 4 1887</b>		9. AGE (In years last birthday) <b>79</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Eva Benton</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Helen E. Rebstock</b>	
				ADDRESS <b>415 E. Gittings St</b>			
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic heart disease</b> DUE TO <b>General arteriosclerosis</b> DUE TO <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>years</b>							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>none</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <b>none</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>9-30-</b> <b>19 63</b> to <b>6-28-</b> <b>1967</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>6-21-67</b> <b>19</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.							
23A. SIGNATURE  C. C. Chiu						23B. DATE SIGNED <b>6-29-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>C. C. Chiu</b>				23D. ADDRESS <b>1 E. Randall Street, Baltimore, Md. 21230</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7 1 1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn, A. A. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Mc Cully</b>		ADDRESS <b>130 E. Fort Ave</b>	

*McGowan*



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6262</b>	
BIRTH NO. <b>67 6262</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Milton W. Hall</b>		2. DATE AND HOUR OF DEATH <b>6-28-67 1:05 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>3-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 Church Home + Hosp.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto.</b>			
		D. STREET ADDRESS (If rural, give location) <b>1607 E. Balto. St.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>5-17-09</b>	9. AGE (In years lost birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Prst.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		11. BIRTHPLACE (State and foreign country) <b>CRISFIELD, MD.</b>	
13. FATHER'S NAME <b>JACKSON HALL</b>		14. MOTHER'S MAIDEN NAME <b>UNK</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217 245938</b>		17. INFORMANT <b>HARVEY M. HALL #2</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>593X</b>		(A) DUE TO <b>Thromb</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Coronal Failure</b>		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-20</b> 19 <b>67</b> to <b>6-28</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-28</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rodelio M. Lim</b> M.D.				23B. DATE SIGNED <b>6-28-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Rodelio M. Lim</b> M.D.		23D. ADDRESS <b>Church Home + Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/30/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Bluff Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>John M. Taylor Sons Annapolis Md.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

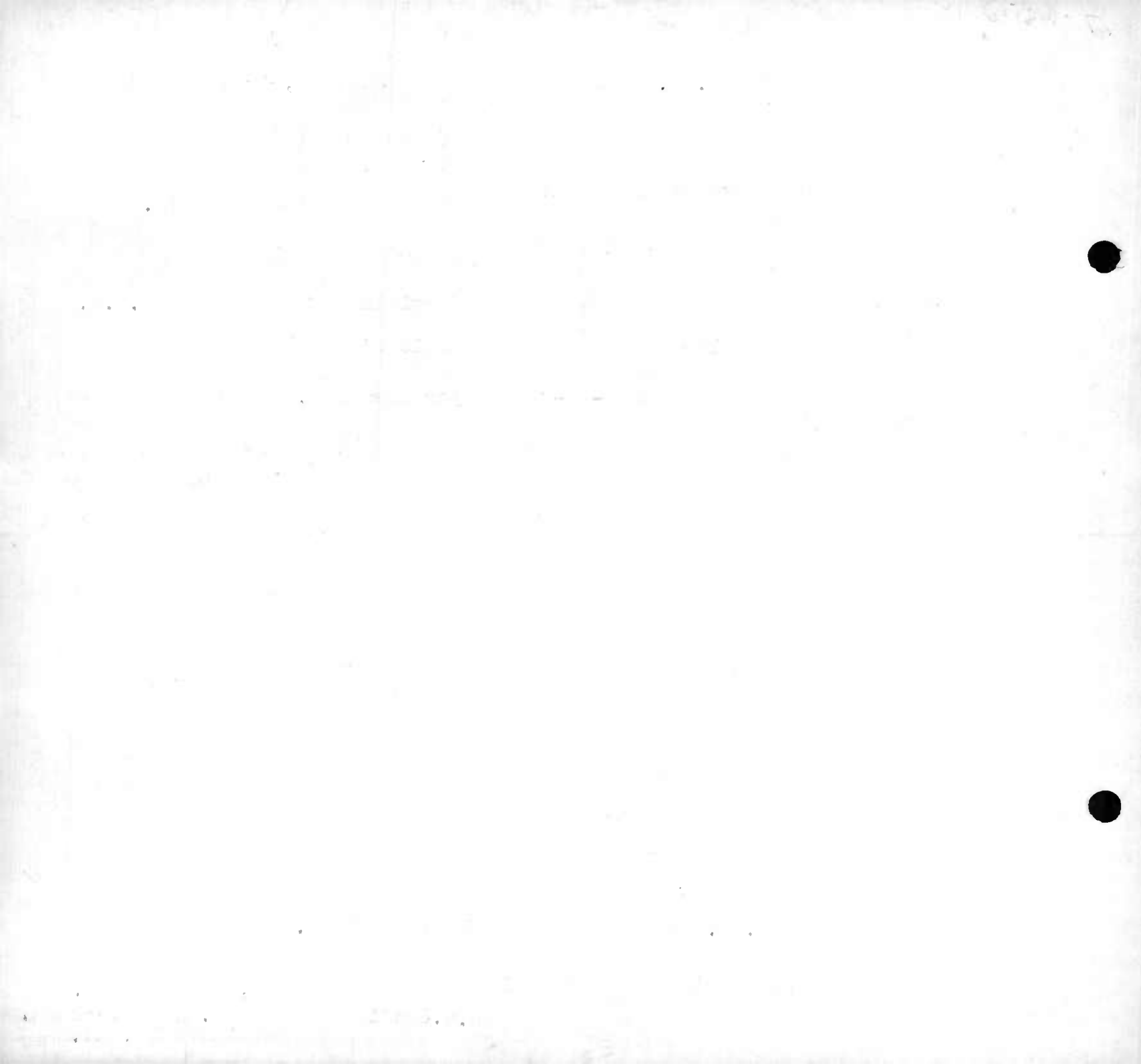
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 6263		67 6263	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Lydia Todd		2. DATE AND HOUR OF DEATH 6-28-67 9 30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 00 610 Somerset Road		D. STREET ADDRESS (If rural, give location) 610 Somerset Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 8/11/1904	9. AGE (In years last birthday) 62	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Feature-Writer		10B. KIND OF BUSINESS OR INDUSTRY Balto. News American		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Frederick C. Todd		14. MOTHER'S MAIDEN NAME Franc Gardiner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-03-8828		17. INFORMANT E. McClure Rozer, 316 Equitable Bldg.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260 X I DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Coronary arrest (B) DUE TO Arteriosclerotic heart disease - CHF (C) DUE TO Subacute myocarditis		INTERVAL BETWEEN ONSET AND DEATH Minutes Year Years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Mar 19 66 to Jan 19 67, that (2) (we) lost saw the deceased alive on 6-3-67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE RK Gundry		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-28-67	
23C. PHYSICIAN'S NAME (Type) RICHARD K. GUNDRY, M.D.		23D. ADDRESS 2 W. University Parkway, 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/67		24C. NAME OF CEMETERY or CREMATORY St. Thomas	
24D. LOCATION (City, town, or county) (State) Garrison Forest, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1967			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

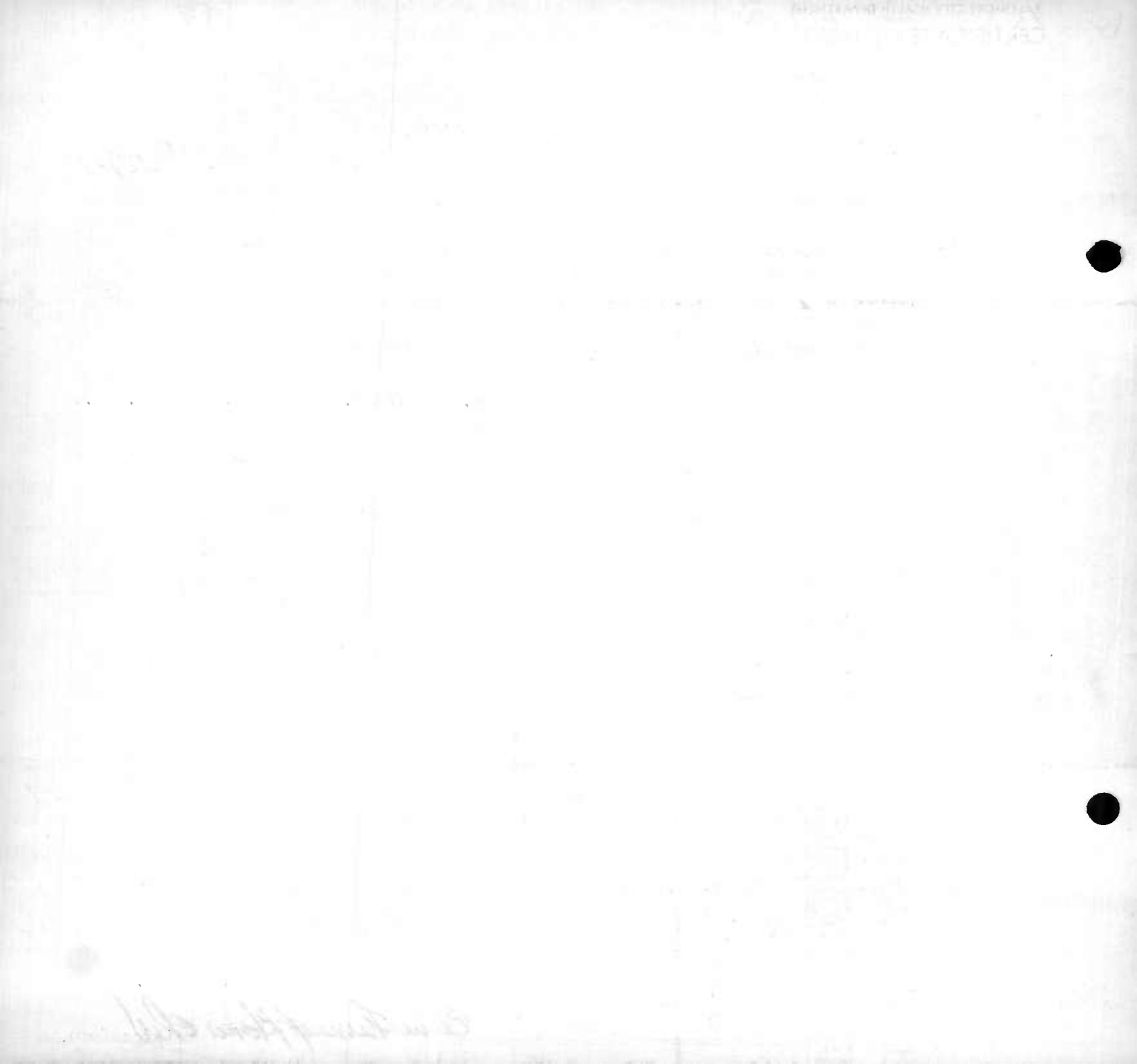
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 6264</span>	
BIRTH NO. <span style="float: right;">67 6264</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Anita E. M. Horan		June 27, 1967 10 <sup>30</sup> P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  90 Long Green Nursing Home		A. STATE Virginia			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Annandale			
		D. STREET ADDRESS (If rural, give location) 8416 Queen Elizabeth Blvd.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4/20/1895	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Thomas Walton Staglor		14. MOTHER'S MAIDEN NAME Annie O'Donnell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-07-2570		17. INFORMANT Major Edward P. Matthews	
				ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  260X I CAUSE OF DEATH Seregestive Heart Failure Coronary Sclerotic Heart Disease Hypertension Diabetes Mellitus  INTERVAL BETWEEN ONSET AND DEATH 2-3 mths 11 10 yrs					
19. ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 24 1967 to June 27 1967, that (I) (we) last saw the deceased alive on June 27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. H. Woody				23B. DATE SIGNED 6-29-67	
23C. PHYSICIAN'S NAME (Type) W. H. Woody				23D. ADDRESS 1403 Park Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/1967		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. JUN 30 1967		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">67 6265</span>	
BIRTH NO. <span style="font-size: 1.2em;">67 6265</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">RHODA R. GROVER</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">6-27-67</span> <span style="font-size: 1.2em;">1<sup>10</sup> P</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">LUTHERAN HOSPITAL OF MARYLAND</span>			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span> <span style="font-size: 1.2em;">27-18</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">4016 HAYWARD AVE</span>		
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">6-29-07</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">59</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">William Becraft</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Emma Tillman</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-20-0074</span>			17. INFORMANT <span style="font-size: 1.2em;">Mr. Charles F. Grover Jr.</span>		
ADDRESS <span style="font-size: 1.2em;">Balto. Md..</span>					
18. <span style="font-size: 1.2em;">175.0 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH <span style="font-size: 1.2em;">METASTATIC CARCINOMA</span> (A) DUE TO  <span style="font-size: 1.2em;">OVARIAN CARCINOMA</span> (B) DUE TO (C) _____  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? <span style="font-size: 1.2em;">No</span> or <span style="font-size: 1.2em;">Yes</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">6-11</span> 19 <span style="font-size: 1.2em;">67</span> to <span style="font-size: 1.2em;">6-27</span> 19 <span style="font-size: 1.2em;">67</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">6-27</span> 19 <span style="font-size: 1.2em;">67</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Lucas E. Vidhyaphum</span> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <span style="font-size: 1.2em;">6-27-67</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">LUCAS E. VIDHYAPHUM</span> M.D.				23D. ADDRESS <span style="font-size: 1.2em;">Lutheran Hospital of Maryland</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">June 30, 67</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">New Oakland</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Carroll Co. Md.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 30 1967</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">R. E. E. Taylor, Jr.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Clive Hummel</span> ADDRESS <span style="font-size: 1.2em;">Pikesville, Md.</span>	

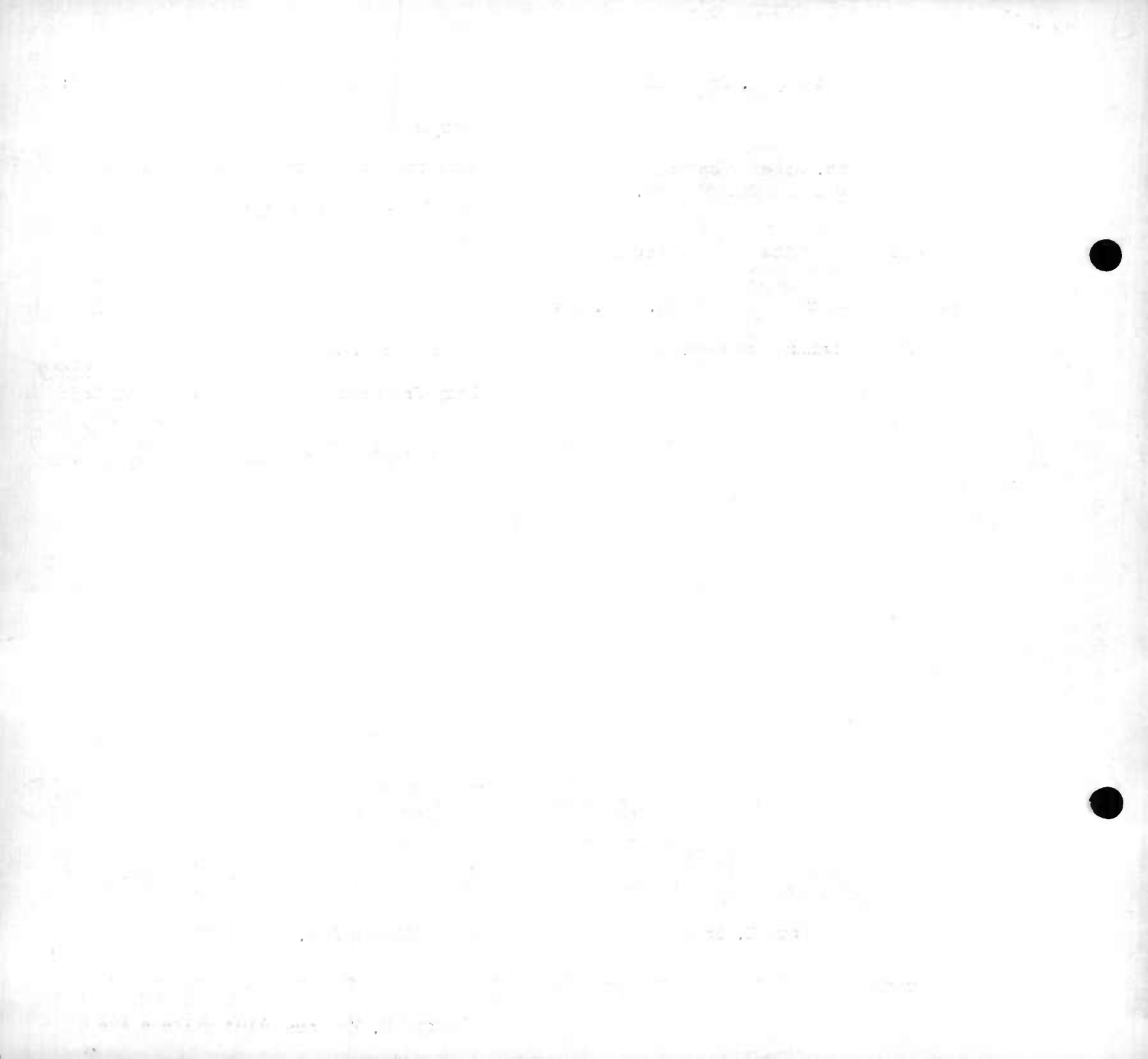




FUNERAL DIRECTOR: IMPORTANT

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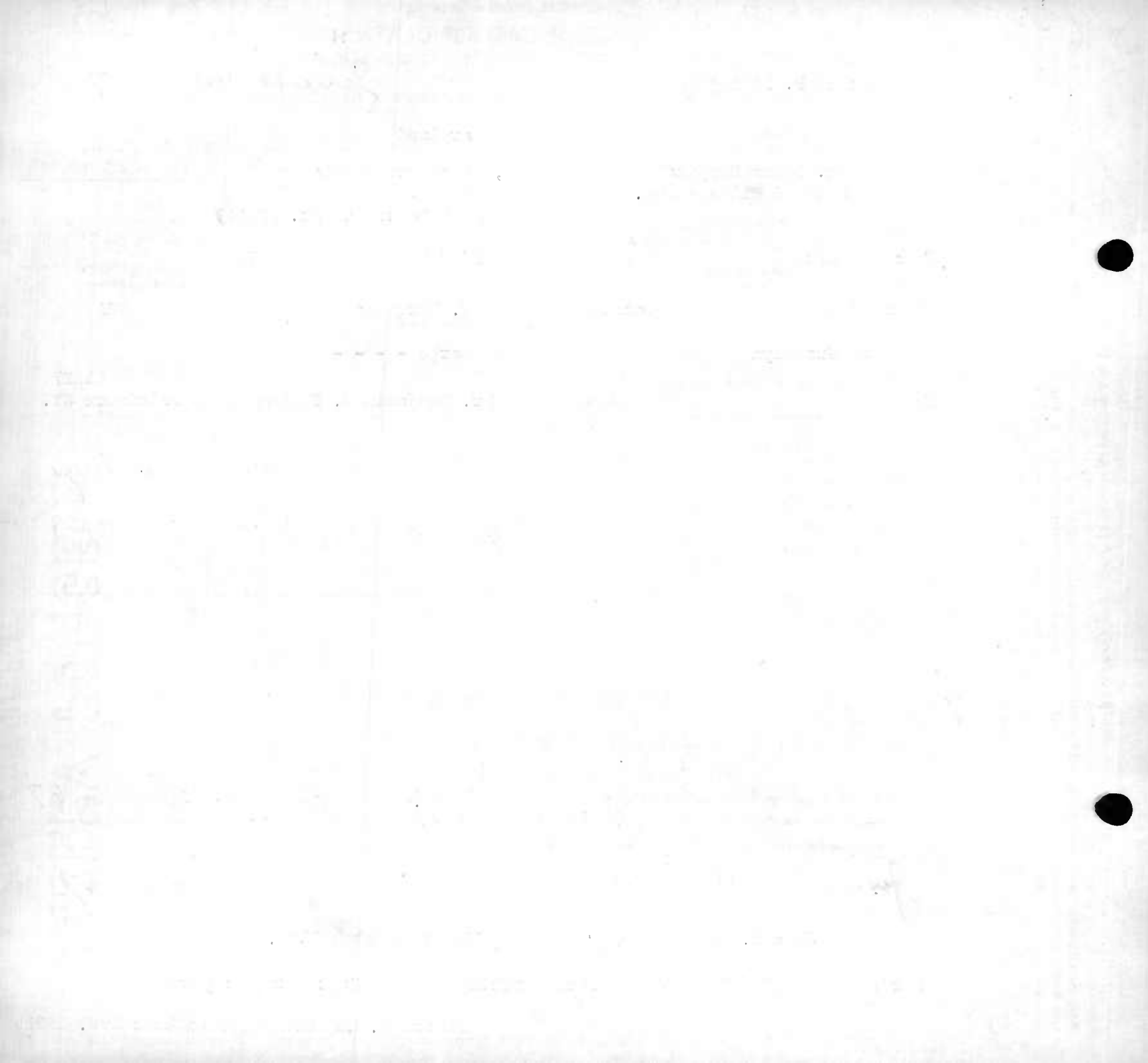
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6266</b>	
BIRTH NO. <b>67 6266</b>		<b>CERTIFICATE OF DEATH</b>		2. DATE AND HOUR OF DEATH <b>6-27-67 4:15 M.</b>	
1. NAME OF DECEASED (Type or Print) <b>Anthony B. Jacobski</b>				P	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>40 St. Agnes Hospital Caton &amp; Wilkens Ave.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Arbutus Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <b>16 Oaklee Village 21229</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>6/11/03</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Bus. Forms</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>Joseph <del>Zachaz</del> Zakubowski</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mary Jacobski 16 Oaklee Village 21229</b>	
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <i>Arteriosclerosis</i> (A) DUE TO (B) DUE TO (C) DUE TO <b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>36 hrs</i>		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-27-67</b> 19 <b>67</b> to <b>6-27</b> 19 <b>67</b> , that (I) <del>was</del> lost saw the deceased alive on <b>6-27</b> 19 <b>67</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Earl I. Pass</i>				23B. DATE SIGNED <b>6-28-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Earl I. Pass</b>				23D. ADDRESS <b>4001 Wilkens Ave. 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/1/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Chicopee Cemetery</b>	
24D. LOCATION <b>Chicopee, Massachusetts</b>		24E. ADDRESS <b>Balto., Md. 21229</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <i>Robert E. Hubbard</i>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard 4107 Wilkens Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6267	
BIRTH NO. 67 6267		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Ethel P. Poling</b>		2. DATE AND HOUR OF DEATH <b>June 26, 1967 7 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto Co.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Highlands</b> D. STREET ADDRESS (If rural, give location) <b>3806 Baltimore St. 21227</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 St. Agnes Hospital Caton &amp; Wilkens Ave.</b>		5. SEX <b>Female</b> 6. RACE <b>White</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>3/6/92</b> 9. AGE (In years last birthday) <b>75</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>W. Virginia</b>	
13. FATHER'S NAME <b>William Franklyn</b>		14. MOTHER'S MAIDEN NAME <b>Marge - - -</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Benjamin W. Poling 3806 Baltimore St.</b>	
18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		(A) <b>Cerebral Thrombosis</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Hypertensive Cardiac Vascular Disease</b> DUE TO		<b>12 years</b>	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/22 1947</b> to <b>6/26 1967</b> , that (I) (we) last saw the deceased alive on <b>6/26 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John P. Urlock Jr</b> M.D.				23B. DATE SIGNED <b>6/28/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>John P. Urlock Jr</b>				23D. ADDRESS <b>1227 Washington Blvd.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/29/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		25D. ADDRESS <b>4107 Wilkens Ave. 21229</b>			

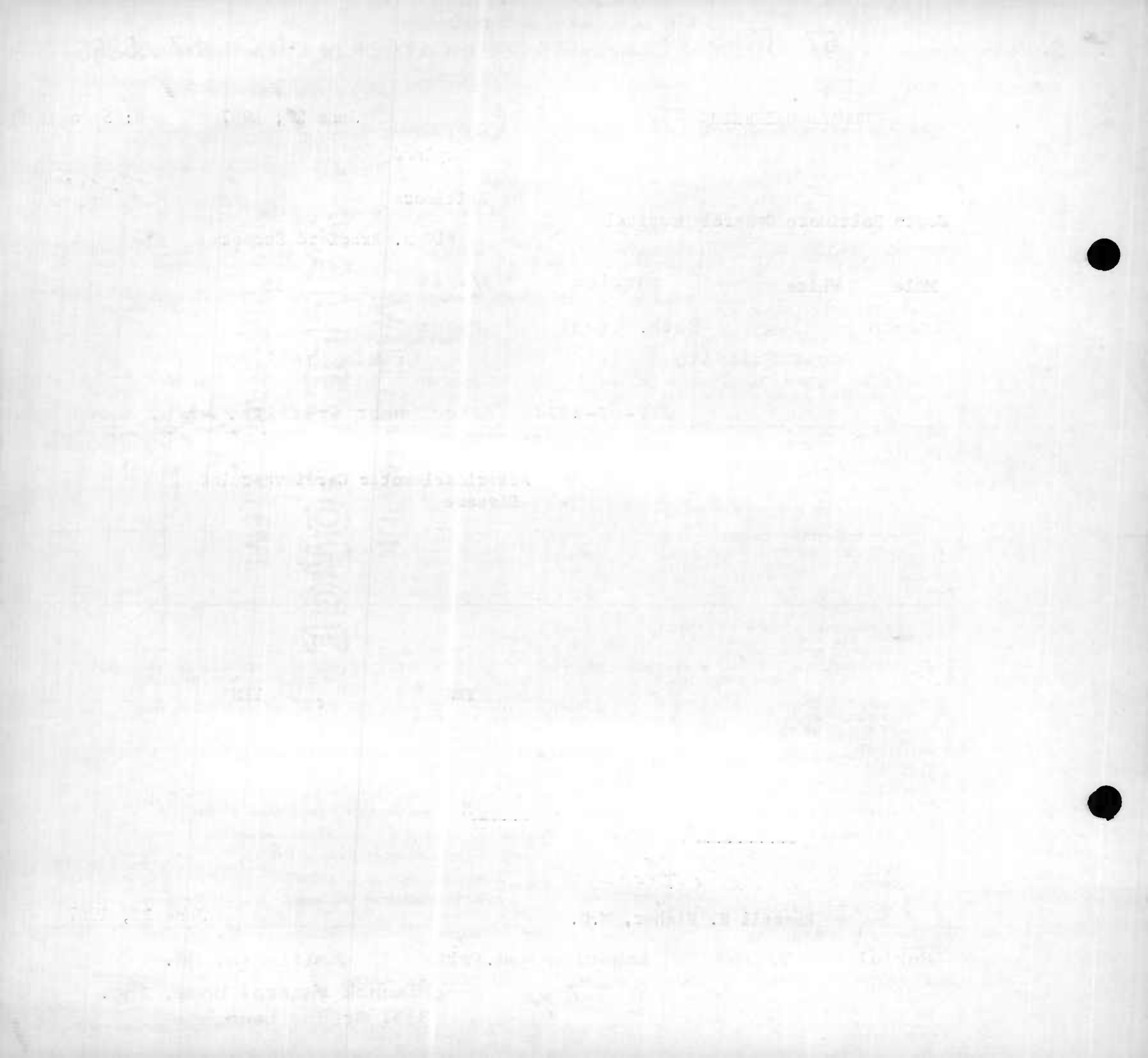


1  
G. 613

BIRTH NO. 67 6268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6268

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>S. EDWARD GRIFFITH SR.</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>June 28, 1967 6:45 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>810 N. Bradford Street</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>3/4/14</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Edgar Griffith</b>				14. MOTHER'S MAIDEN NAME <b>Ursula Stallings</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>217-05-3574</b>		17. INFORMANT ADDRESS <b>Alice Weber Griffith, wife, above</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 28, 1967</b>	
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>7/1/67</b>		23C. NAME of CEMETERY or CREMATORY <b>Lakeview Mem. Park</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		24B. NAME OF REGISTRAR <b>R. E. Fisher, M.D.</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>			



K 216

67 6269

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6269

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)W.  
JOHN KASPAR

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1967 5:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 2119 Lake Montebello Terrace

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2119 Lake Montebello Terrace

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
married

8. DATE OF BIRTH

March 4, 1892

9. AGE (in years  
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Music Instructor

10B. KIND OF BUSINESS OR INDUSTRY

self-employed

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John J. Kaspar

14. MOTHER'S MAIDEN NAME

Mary Kaspar

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

216-18-0441

17. INFORMANT

ADDRESS

Agnes Turek Kaspar, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7/3/67

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 30 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
3331 Brehms Lane

ADDRESS

1000

MAILED 1000





1  
M. 520

67 6270

BALTIMORE CITY HEALTH DEPARTMENT

67 6270

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)  
WILLIAM

MUNK

2. DATE AND HOUR PRONOUNCED DEAD

June 26, 1967

6:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 City Hospital (DOA)  
99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

615 S. Rose Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

12-15-1912

9. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Warehouse Manager

10B. KIND OF BUSINESS OR INDUSTRY

Hill Chase Steel

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Wm.

14. MOTHER'S MAIDEN NAME

Moll

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

217-14-3594

17. INFORMANT

Mrs. Julia Munk

ADDRESS

615 S. Rose St.

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/26/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6-30-67

23C. NAME OF CEMETERY or CREMATORY

Oak Lawn

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 30 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Thelma A. Hoffmann

ADDRESS

3218 Hudson St.

REPORT  
TO THE  
PEOPLE

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Annetta Moore

2. DATE AND HOUR OF DEATH

6/27/67

7:30 pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE 21224, MARYLAND

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2832 THE ALAMEDA

21218

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

11-5-03

9. AGE (In years  
last birthday)

63

If Under 1 Yr.

Months Days Hours Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Printer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY MILLS

14. MOTHER'S MAIDEN NAME

SARAH REEDER

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-30-8645

17. INFORMANT

ADDRESS

MD.

RECORDS: BCH 4940 EASTERN AVENUE BALTO. 21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osphenio, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Carcinoma of Breast

6 yrs.

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/19 19 67 to 6/27 19 67  
that (I) (we) last saw the deceased alive on 6/27 19 67 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Wm A. Emerson

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

6/27/67

23C. PHYSICIAN'S  
NAME (Type)

DR. WILLIAM A. EMERSON

23D. ADDRESS

BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

7/1/67

24C. NAME OF CEMETERY or CREMATORY

MT. CALVARY

24D. LOCATION

(City, town, or county) (State)

A.A. County, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 30 1967

25B. NAME OF REGISTRAR

R. E. E. Johnson

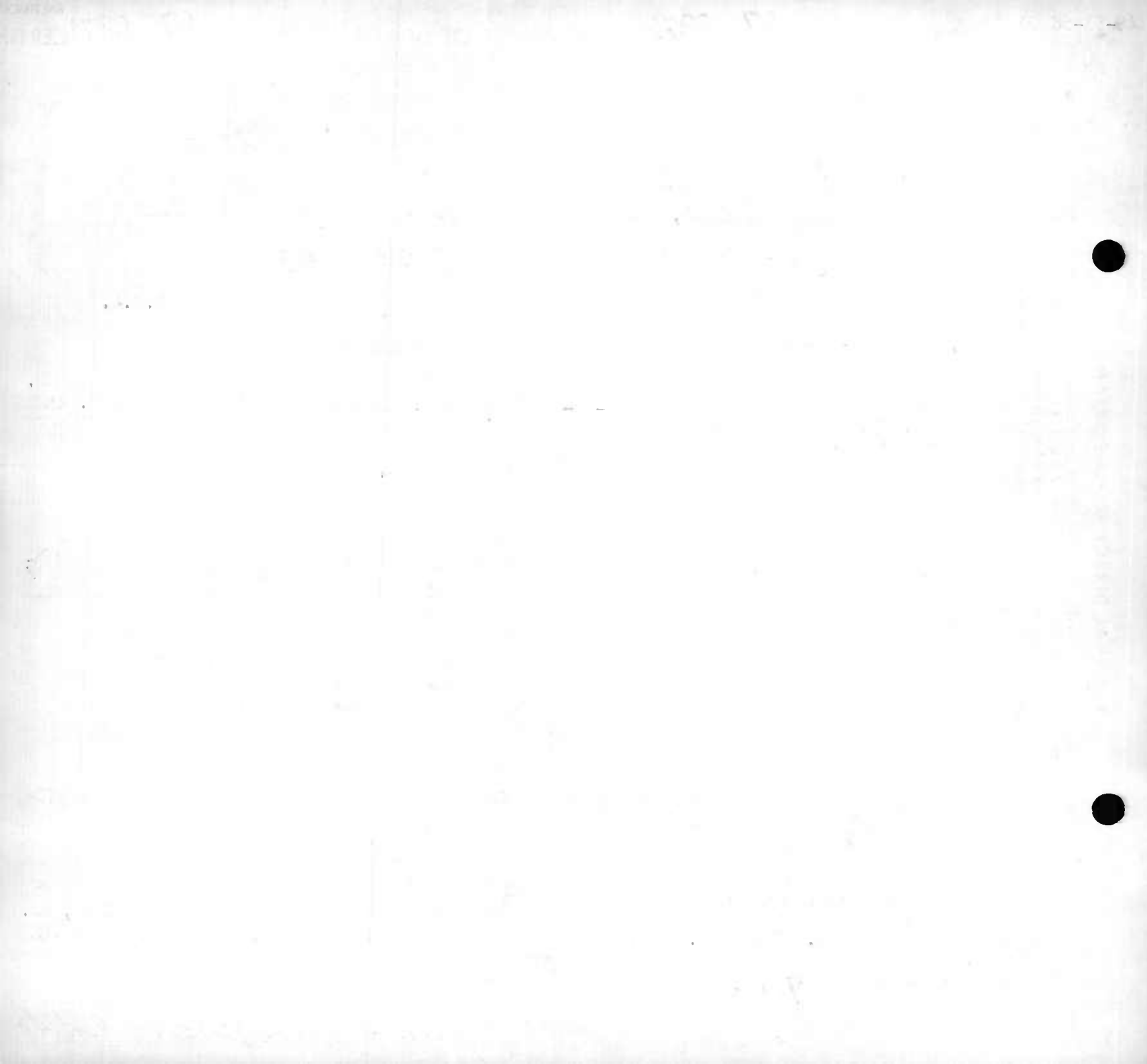
25C. FUNERAL DIRECTOR

Joseph B. Locks 1304 N. Central Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6272	
BIRTH NO. 67 6272		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED HOWARD EMERY PRINKEY		2. DATE AND HOUR OF DEATH 6-27-67 11 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00			
		D. STREET ADDRESS (If rural, give location) 3175 BAYBRIAR ROAD - 21222			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/8/08	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scalman		10B. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME RALPH PRINKEY			14. MOTHER'S MAIDEN NAME GOLDIE (DECEASED)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 191-05-9979		17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DUE TO Gram negative septicemia		CAUSE OF DEATH DUE TO Small bowel ischemia		INTERVAL BETWEEN ONSET AND DEATH 5 days.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		DUE TO AS CVD.			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/18, 6/21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated ulcer, Bowel necrosis		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/18 19 67 to 6-27 19 67, that (2) (we) last saw the deceased alive on 6-27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. J. GILL				23B. DATE SIGNED 6-27-67	
23C. PHYSICIAN'S NAME (Type) A. J. GILL		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/67		24C. NAME OF CEMETERY OR CREMATORY Meadow Ridge Cemetery	
				24D. LOCATION (City, town, or county) (State) Elkridge, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home Dundalk, Md.	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 6273				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6273			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Catherine Homfeldt</i>				2. DATE AND HOUR OF DEATH <i>6-24-67 10:30 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>35 Church Home &amp; Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto. 26-03</i> D. STREET ADDRESS (If rural, give location) <i>3122 Chesterfield Ave.</i>							
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>		8. DATE OF BIRTH <i>JULY 15, 1893</i>		9. AGE (In years last birthday) <i>73</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AT HOME</i>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>ANTON ARNOLD</i>				14. MOTHER'S MAIDEN NAME <i>IDA REYNOLDS</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>214-01-75203</i>		17. INFORMANT <i>HERMAN HOMFELDT</i>				ADDRESS <i>3122 CHESTERFIELD</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>260X1</i>				CAUSE OF DEATH (A) <i>Arterio sclerotic Heart Disease unknown</i> DUE TO (B) <i>Diabetes mellitus.</i> DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>II Diabetes Mellitus;</i>											
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <i>6-24-67</i> to <i>6-24-67</i> , that (I) (we) last saw the deceased alive on <i>6-24-67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Rodelio M. Lim</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED <i>6-24-67</i>			
23C. PHYSICIAN'S NAME (Type) <i>Rodelio M. Lim</i> M.D.								23D. ADDRESS <i>Church Home &amp; Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6/28/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MORELAND PARK</i>		24D. LOCATION (City, town, or county) (State) <i>PARKVILLE MD</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1967</i>				25B. NAME OF REGISTRAR <i>Robert E. Jackson, MD</i>		25C. FUNERAL DIRECTOR ADDRESS <i>ULLRICH FUNERAL HOME 4216 BELAIR</i>					

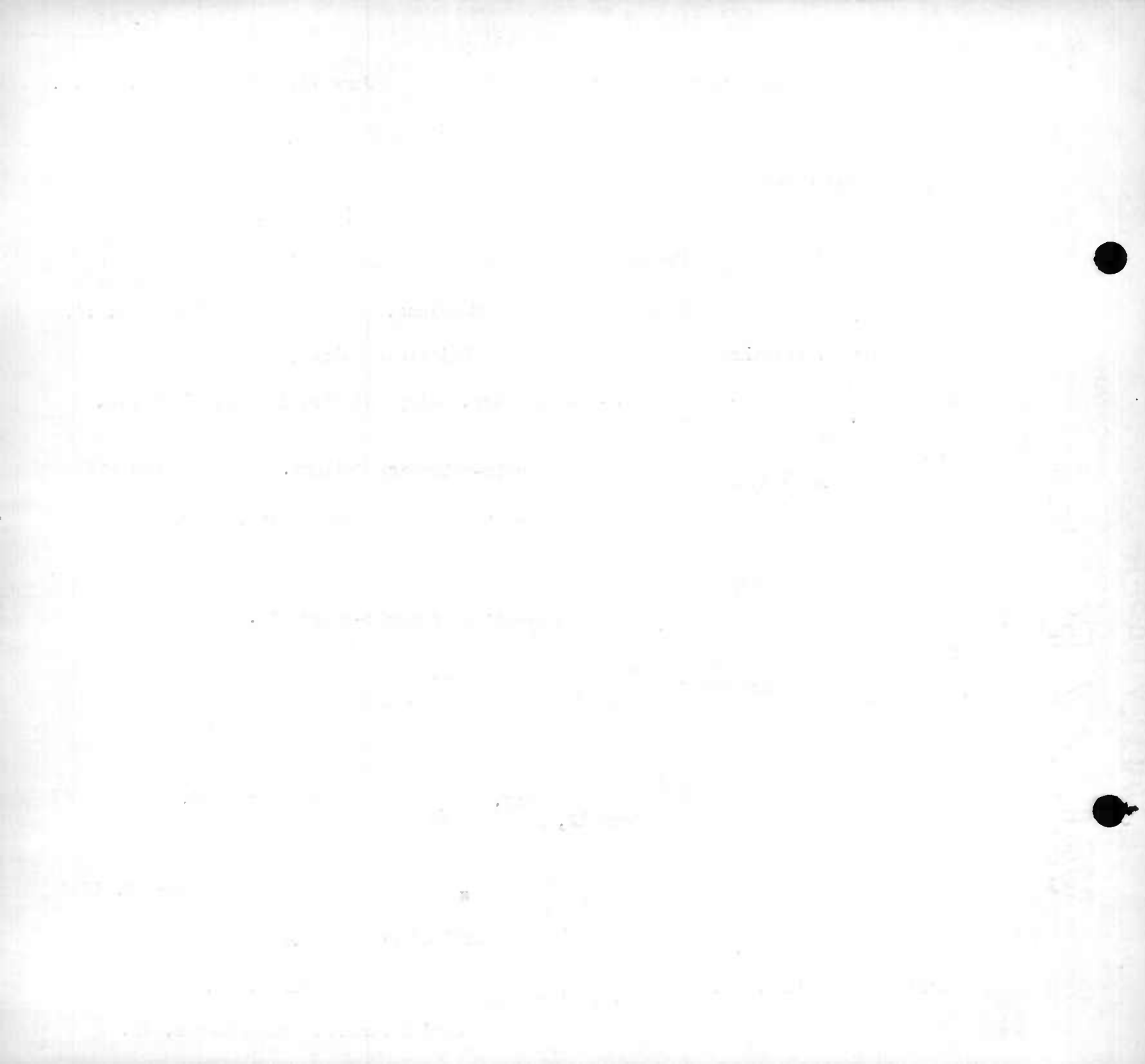




FUNERAL DIRECTOR: IMPORTANT

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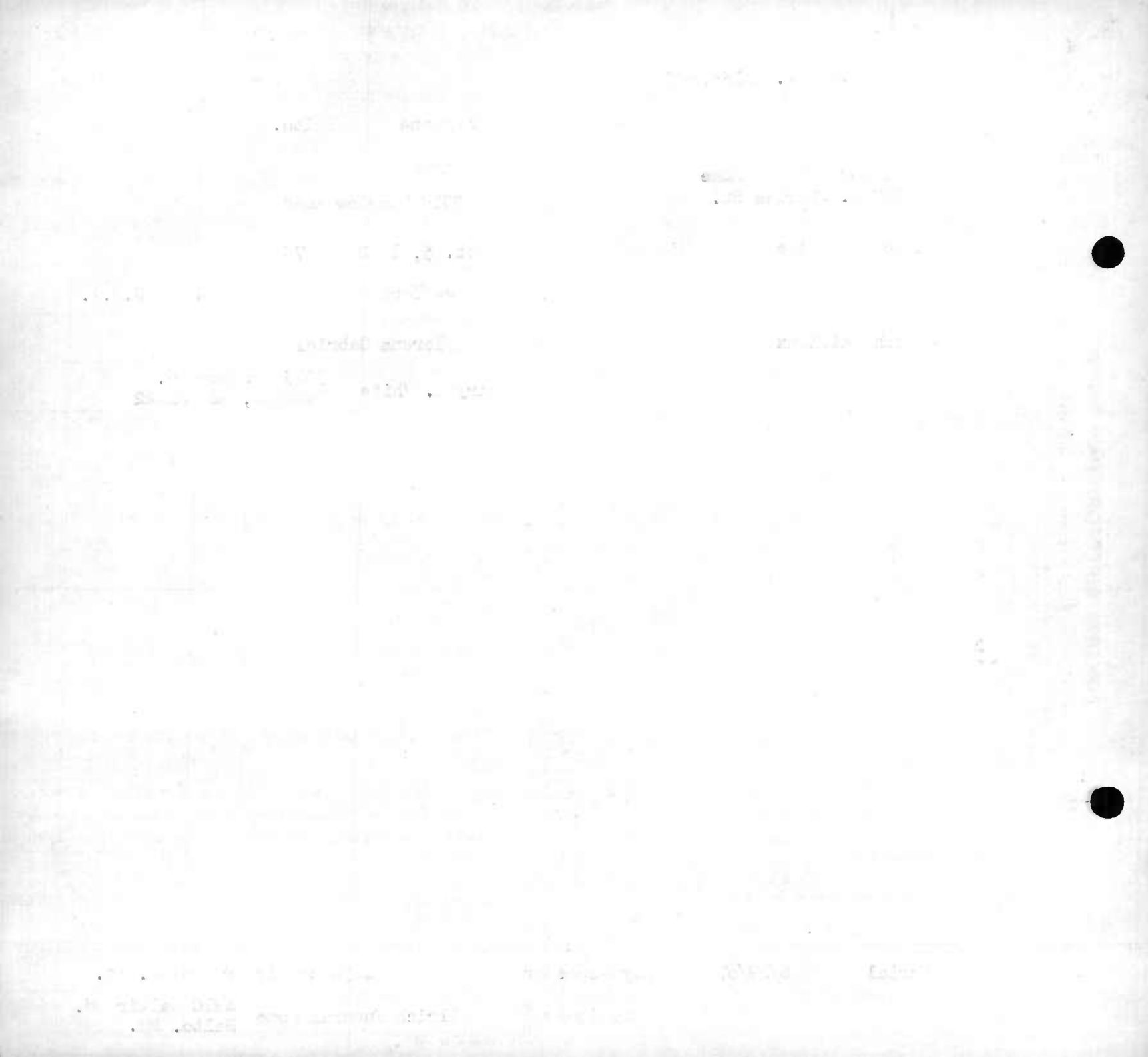
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 6274</span>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO.</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center;"><b>William John Neibuhr</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center;"><b>June 24, 1967 10:26 P.M. M.</b></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="text-align: center;"><b>1109 Steelton Ave.</b></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>Maryland</b> B. COUNTY</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b></p> <p>D. STREET ADDRESS (If rural, give location) <b>1109 Steelton Ave.</b></p>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 26, 1906</b>	9. AGE (In years last birthday) <b>61</b>	<p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Riveter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William H. Neibuhr</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Holzworth</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-01-3210</b>	17. INFORMANT ADDRESS <b>Mrs. Betty Neibuhr, 1109 Steelton Ave.</b>		
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;"><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>			<p>CAUSE OF DEATH</p> <p>(A) <b>Cardio-pulmonary Failure.</b> DUE TO</p> <p>(B) <b>Chronic Pulmonary Emphysema, 10 years</b> DUE TO</p> <p>(C)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p style="text-align: center;"><b>one day</b></p>
<p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			<p style="text-align: center;"><b>Generalized Arterio-Sclerosis.</b> <b>Tracheostomy</b></p>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Emphysema</b>	20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>May, 1963</b> to <b>June 12, 1967</b>, that (I) (we) last saw the deceased alive on <b>June 12, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE <i>Stephen K. Padussis</i>				23B. DATE SIGNED <b>June 27, 1967</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<b>Stephen K. Padussis</b>		<b>6511 O'Donnell St.,</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>June 28, 1967</b>	24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Ullrich Funeral Home Dundalk, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

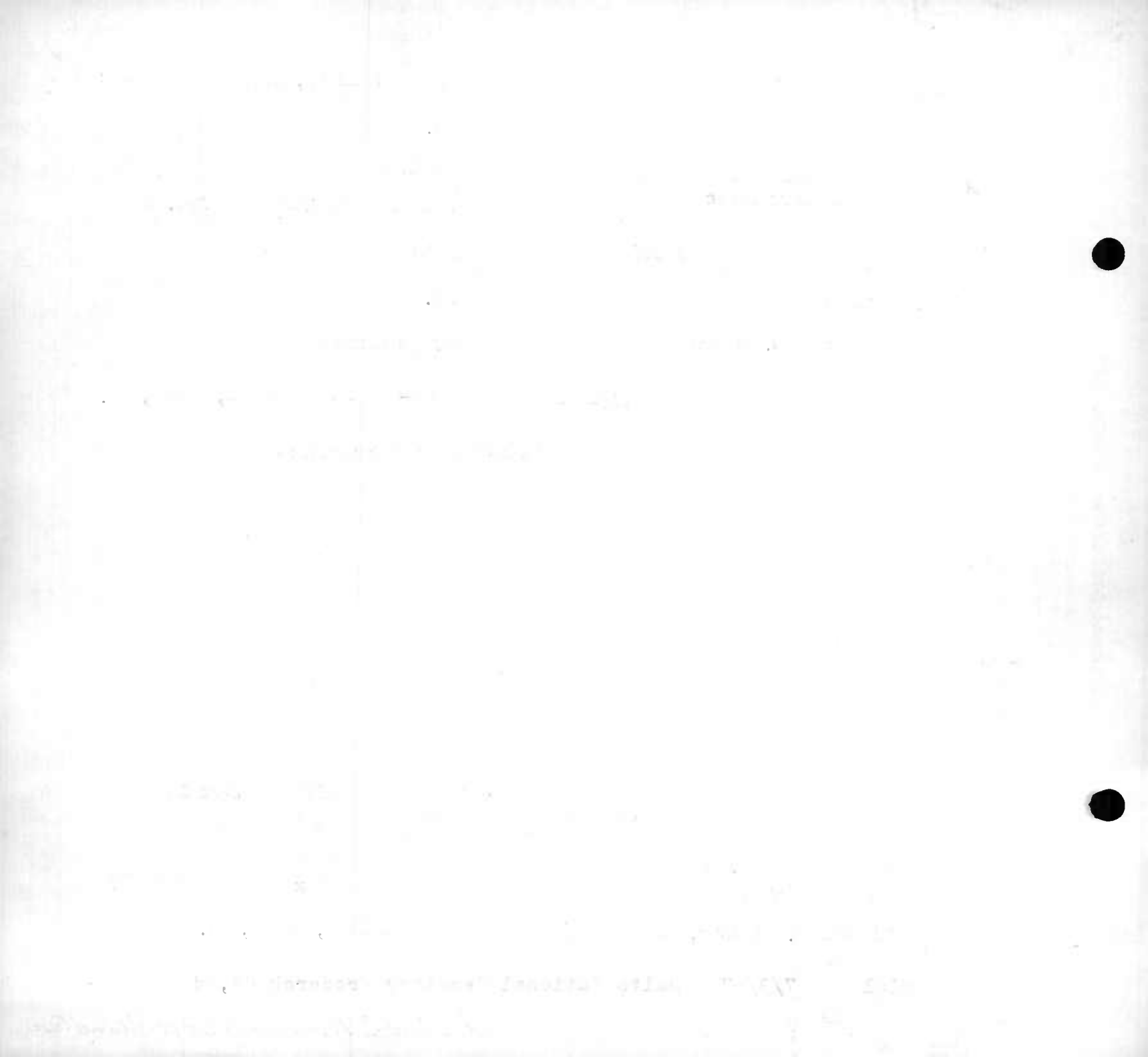
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BIRTH NO. 67 6275				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 6275	
1. NAME OF DECEASED (Type or Print) <b>Agnes A. Coldehoff</b>				2. DATE AND HOUR OF DEATH <b>6-26-67</b> <b>9 P. M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Melchor Nursing Home</b> <b>2327 N. Charles St.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto. Co.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Dundalk</b> <b>53-00</b>			
D. STREET ADDRESS (If rural, give location) <b>3019 Dunglew Road</b>				5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>Feb. 5, 1892</b>		9. AGE (In years last birthday) <b>75</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Mailloux</b>				14. MOTHER'S MAIDEN NAME <b>Colerena Gabriel</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mary E. White</b>		ADDRESS <b>3019 Dunglew Rd.</b> <b>Dundalk, Md 21222</b>			
18. <b>331X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Epileptic Seizures</b>				CAUSE OF DEATH (A) <b>EVA</b> DUE TO (B) <b>Generalized Arteriosclerosis</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Instantaneous</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1963</b> to <b>6-26-1967</b> , that (I) (we) lost saw the deceased alive on <b>6-26-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Cesar Valle Caverio</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6-27-67</b>			
23C. PHYSICIAN'S NAME (Type) <b>CESAR VALLE CAVERIO</b>				23D. ADDRESS <b>36 29 Liberty Rd.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/29/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Ullrich Funeral Home</b>		ADDRESS <b>4210 Belair Rd. Balto. Md.</b>			



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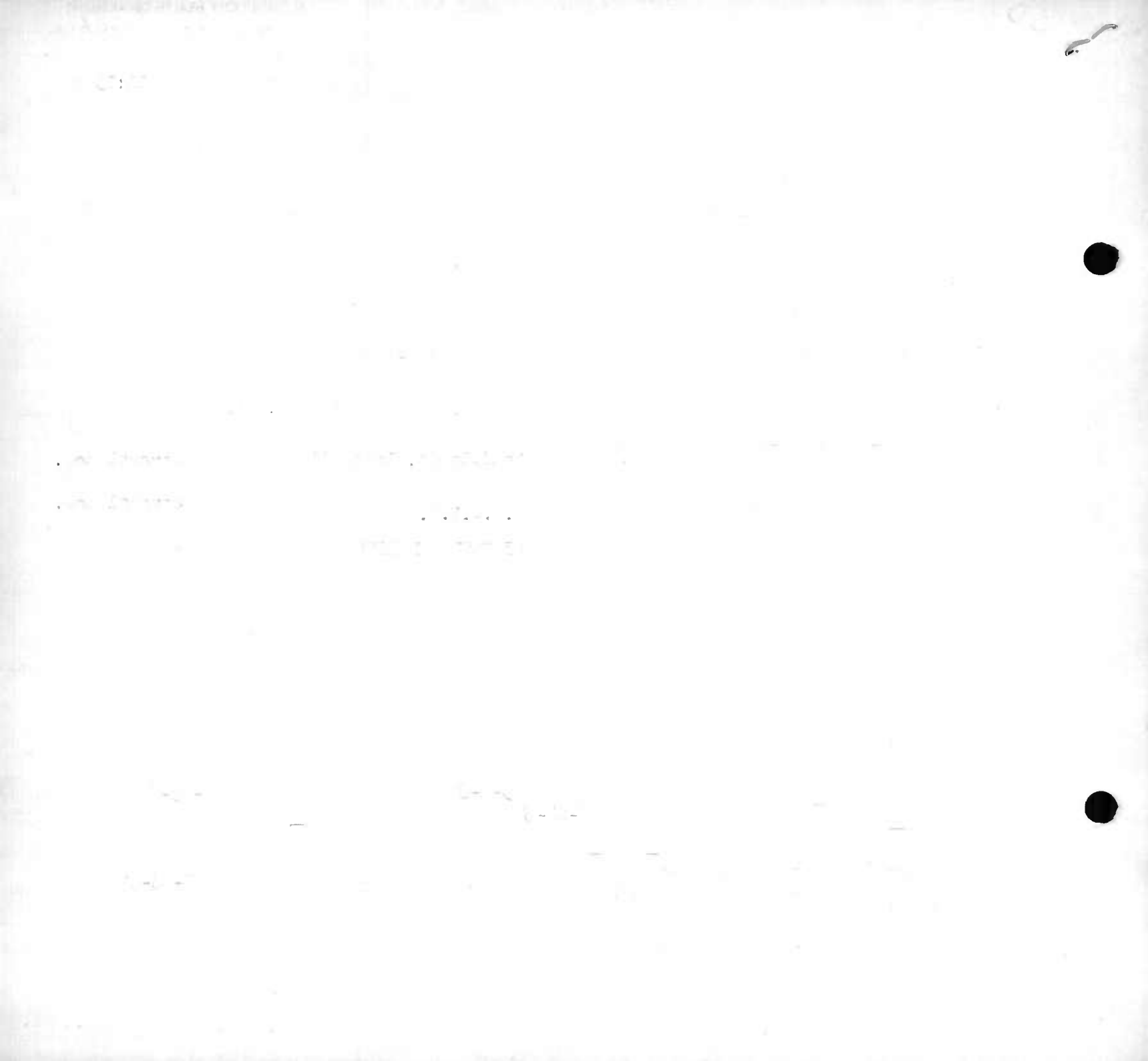
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6276</u>	
BIRTH NO. <u>67 6276</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Doris Leona Gilmore</u>		2. DATE AND HOUR OF DEATH <u>June 29, 1967</u> <u>10:20</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Prince Georges Co.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>US Public Health Service Hospital</u> <u>3100 Wyman Park Drive</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Suitland</u>			
		D. STREET ADDRESS (If rural, give location) <u>3016 Parkway Terrace</u> <u>Apt. 6</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>7/21/32</u>	9. AGE (In years lost birthday) <u>34</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Marvin C. Mather</u>		14. MOTHER'S MAIDEN NAME <u>Gladys Mixter</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-28-9669</u>		17. INFORMANT ADDRESS <u>Records- US PHS Hospital, Balto, Md.</u>	
18. <u>199.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) <u>Metastatic adenocarcinoma</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I/this hospital) attended the deceased from <u>May 29</u> <u>1967</u> to <u>June 29</u> <u>1967</u> , that (I/we) last saw the deceased alive on <u>June 29</u> <u>1967</u> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael E. Pelczar</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>6/29/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael E. Pelczar, SA Surg (R)</u> M.D.		23D. ADDRESS <u>US PHS Hospital, Balto, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/3/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Balto National Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Frederck Rd, Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Austin E. Donovan - 3818 Roland Ave</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6277				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6277	
1. NAME OF DECEASED (Type or Print) <b>JOSEPH KALIN</b>				2. DATE AND HOUR OF DEATH <b>June 25, 1967 11:15 P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Bolton Hill Nursing Home</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 14-01</b>			
				D. STREET ADDRESS (If rural, give location) <b>Bolton Hill Nursing Home</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>Oct. 19, 1905</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pattern Cutter</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Benjamin Kalin</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Siegel</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT ADDRESS <b>Mr. Rubin Kalin, 4537 Pimlico Road #15</b>	
18. <b>260 X I</b>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) <b>hemiplegia, left side</b>		INTERVAL BETWEEN ONSET AND DEATH <b>several mos.</b>	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO			
ANTECEDENT CAUSES				(B) <b>A.S.C.V.D.</b>		<b>several mos.</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO <b>DIABETES MELLITUS</b>		<b>?</b>	
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5-8-67</b> 19 to <b>6-25-67</b> 19, that (I) (we) lost saw the deceased alive on <b>6-24-67</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>E. Ellsworth Cook</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6-26-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Ellsworth E. Cook</b>				23D. ADDRESS <b>2431 Maryland Avenue</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/28/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Beth Jacob (Vear)</b>		24D. LOCATION (City, town, or county) (State) <b>Rosedale, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</b>		ADDRESS	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6278		CERTIFICATE OF DEATH		Registered No. 67 6278	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>SCHUMAN, LEWIS NMI</b>			
2. DATE AND HOUR OF DEATH <b>June 27, 1967</b>				8:25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION <b>27 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto. Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>6739 Townbrook Drive, Apt. A</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7/12/98</b>	9. AGE (In years lost birthday) <b>68</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Postal Service</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harris Schuman</b>				14. MOTHER'S MAIDEN NAME <b>Sara Katzman</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3/26/17-6/4/19</b>		16. SOCIAL SECURITY NO. <b>548-42-2772</b>		17. INFORMANT ADDRESS <b>VA Hospital Records, Baltimore, Md. 2128</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>C V A</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Severe Emphysema</b>				Years - unknown <b>20 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 7th 1967</b> to <b>June 27th 1967</b> , that (I) (we) last saw the deceased alive on <b>June 27th 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Allen D. Johnson</b>				23B. DATE SIGNED <b>June 27, 1967</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>ALLEN D. JOHNSON</b>				23D. ADDRESS <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd., Balto., Md 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/28/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Jewish War Veteran Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Rosedale, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</b>			

Letter from Veterans Administration Hospital  
8-8-67 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6279</b>	
BIRTH NO. <b>67 6279</b>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>Philip A. LEHMAN</b>			2. DATE AND HOUR OF DEATH <b>6-27-67 4:35 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>44 Union Memorial Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2217 Cross Country Blvd</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11-11-10</b>	9. AGE (In years last birthday) <b>56</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self employed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Business Forms</b>		11. BIRTHPLACE (State or foreign country) <b>Balto Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Alfred Lehman</b>		
14. MOTHER'S MAIDEN NAME <b>Etta RONSHEIM</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES U.S. 11 ARMY</b>		
16. SOCIAL SECURITY NO. <b>217-07-8476</b>		17. INFORMANT <b>Patient chart</b>			
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <b>Acute Infarction of left ventricle</b> (B) DUE TO <b>in revascular</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>7-20-68</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>YES</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from <b>6-26 1967</b> to <b>6-27 1967</b> , that (we) lost saw the deceased alive on <b>6-27 1967</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John R. Vaughn, Jr.</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>6-27-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN R. VAUGHN, JR., M.D.</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/28/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Hebrew</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</b>			

2 July 1910

My dear Mr. ...

Union Memorial Hospital 2117 Cross County Blvd

Male White Married 11-11-10 20

Self employed business firm - Maryland U.S.

Alfred L. ...

Patent agent

~~Address ...~~

Route 1, Baltimore

Yours

John ...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6280</b>	
BIRTH NO. <b>97703 6280</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <b>97703 6280</b>		1. NAME OF DECEASED <b>Rosenthal, <del>XXXXXX</del> Hyman</b>		2. DATE AND HOUR OF DEATH <b>1:46 PM JUNE 26, 1967</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4 Bon Secour Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give town) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2237 Rogene Drive</b>			
5. SEX <b>Male</b>	6. RACE <b>white</b>	7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>3/4/1876</b>	9. AGE (In years lost birthday) <b>91</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Instructor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Designer</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
13. FATHER'S NAME <b>Jacob Rosenthal</b>		14. MOTHER'S MAIDEN NAME <b>Riva</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-7597</b>		17. INFORMANT <b>Mr. M. Samuel Rosenthal, 2237 Rogene Drive</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>332X</b>		CAUSE OF DEATH (A) DUE TO <b>Cerebral Thrombosis</b> (B) DUE TO <b>I.C.V.A.</b> (C) _____			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>June 19th</u> 19 <u>67</u> to <u>June 26</u> 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>JUNE 26</u> 19 <u>67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <b>S. R. Jank</b>				23B. DATE SIGNED <b>6/26/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>SAI ROK PARK</b>				23D. ADDRESS <b>Bon Secour Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/28/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Anshe Nesina</b>	
24D. LOCATION (City, town or county) (State) <b>Rosedale, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>			
25B. NAME OF REGISTRAR <b>A. E. E. Jank</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sol Levinson &amp; Bros., Inc., 6010 Reist., Pd.</b>			



48-44-27TN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6281		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6281	
M.E. CASE NO. BCH # 48 44 27		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) EDITH N. FIELDS (GRAVES)		2. DATE AND HOUR OF DEATH 6/29/67 12 30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 31 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		A. STATE MARYLAND B. COUNTY 8-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1809 N. COLLINGTON AVENUE 21213			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-25-26	9. AGE (In years lost birthday) 40	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SHAD HAIRSTON			14. MOTHER'S MAIDEN NAME RENDY BROADNAX		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS BCH:RECORDS 4940 EASTERN AVENUE 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 330 XI 008.1 Pneumonia Subarachnoid hemorrhage INTERVAL BETWEEN ONSET AND DEATH 1 week 1 1/2 weeks		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO TB			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from 1/5 1967 to 6/29 1967, that (I) (we) lost saw the deceased alive on 6/29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Phillip L. Hall		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/29/67	
23C. PHYSICIAN'S NAME (Type) DR. PHILLIP L. HALL		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO. MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem	
				24D. LOCATION (City, town, or county) (State) BALTO MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1967		25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR ADDRESS WIM C MARCH 928 E. NORTH AVE	

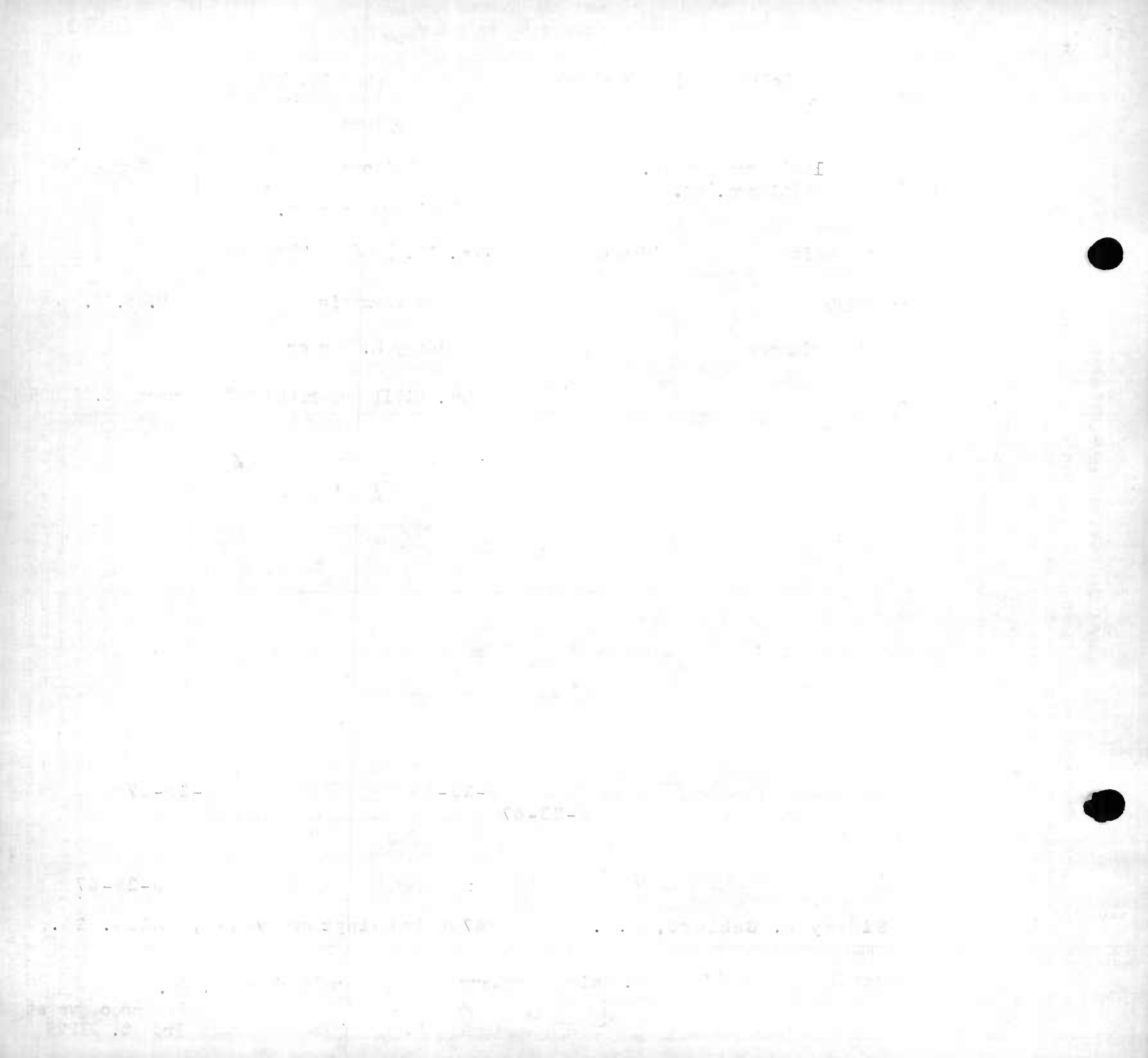




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

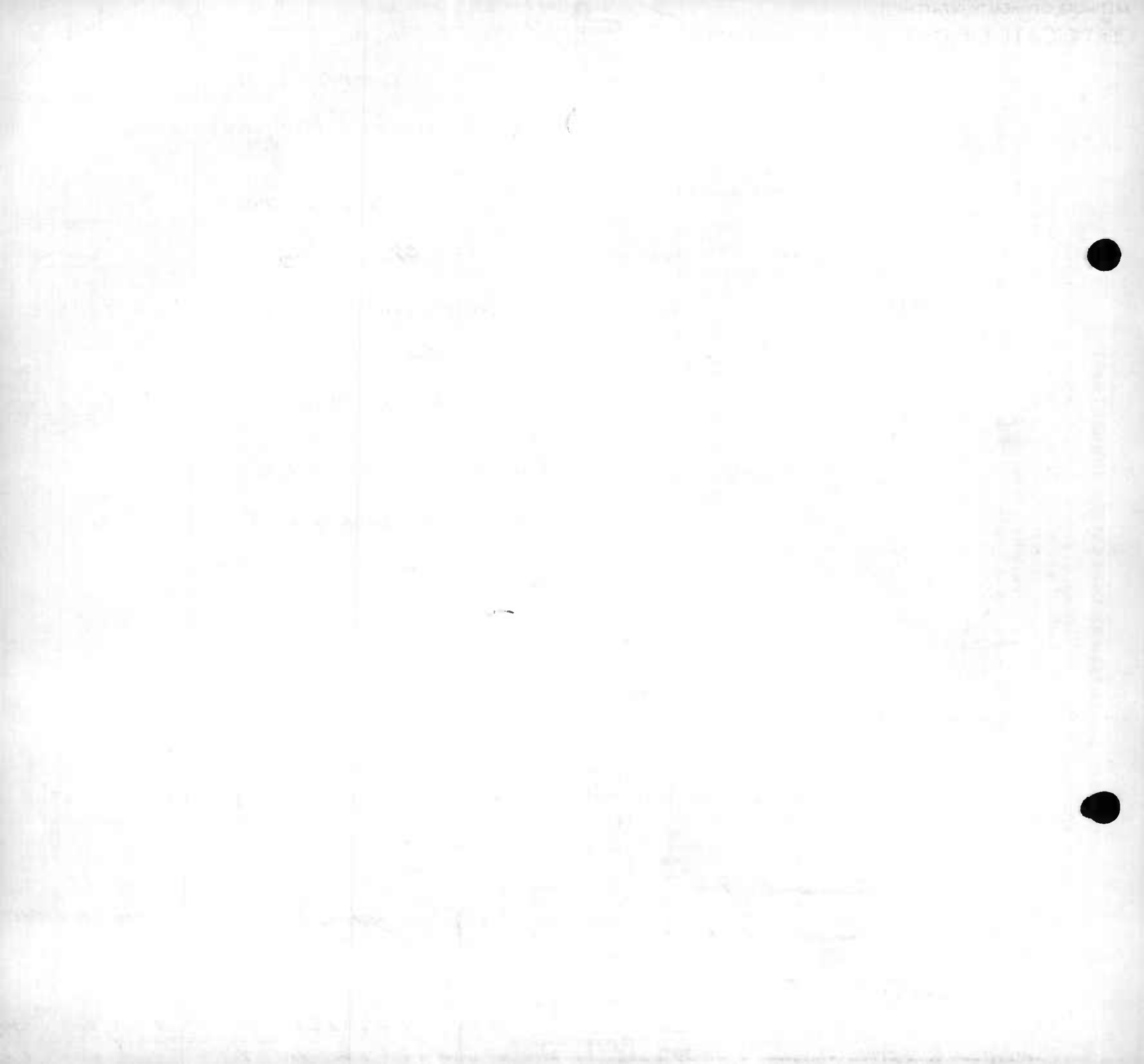
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6282</b>	
BIRTH NO. <b>67 6282</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Lelah Bernice Hornbeck</b>		2. DATE AND HOUR OF DEATH <b>June 29, 1967</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1523 Sycamore St. Baltimore, Md.</b>		A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1523 Sycamore St.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	B. DATE OF BIRTH <b>Jan. 28, 1896</b>	9. AGE (In years lost birthday) <b>71 years</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Clinton Simmons</b>		14. MOTHER'S MAIDEN NAME <b>Sidney R. Taylor</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Sibil McFarland 1526 Church St. 21225</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CA of cervix uteri with metastases</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-23-66</b> to <b>6-29-67</b> and that (I) (we) last saw the deceased alive on <b>6-23-67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sidney R. Gehlert</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6-29-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Sidney R. Gehlert, M.D.</b>		23D. ADDRESS <b>4700 Pennington Avenue, Balto. 26.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>6/29/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Union Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Buckhannon W. Va.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>McCall Funeral Home</b>		ADDRESS <b>Patapsco Ave at 3rd St. 21225</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6283</b>	
BIRTH NO. <b>67 6283</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>GODSEY JACK</b>		2. DATE AND HOUR OF DEATH <b>12:05PM, 6/28/67</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>BALTIMORE, MARYLAND 21202</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARYLAND</b> <b>730 - ASHBURTON STREET</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>719, E. PRESTON STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6-6-02</b>	9. AGE (In years lost birthday) <b>65</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction work</b>		11. BIRTHPLACE (State or foreign country) <b>Drakes Branch, Virginia</b>	
13. FATHER'S NAME <b>William Godsey</b>		14. MOTHER'S MAIDEN NAME <b>Ida Godsey</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>294-07-4018</b>		17. INFORMANT <b>Mrs. Pauline Godsey</b>	
18. <b>443 XI</b>		CAUSE OF DEATH			ADDRESS <b>806 Wildwood PK.</b>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>PNEUMONIA LEFT LOWER LOBE</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES		(B) <b>EMPHYEMA Secondary to (A)</b> DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>CEREBRAL ARTERIOSCLEROSIS, MULTIPLE STROKES</b> <b>H.C.V.D.</b>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-29-1967</b> to <b>6-28-1967</b> , that (I) (we) last saw the deceased alive on <b>6-28-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thankam B. Pillai</b>				23B. DATE SIGNED <b>6-28-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>THANKAM B. PILLAI</b>				23D. ADDRESS <b>LUTHERAN HOSPITAL OF MARYLAND, 730-ASHBURTON STREET</b> <b>BALTIMORE Md 21216</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7-1-67</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. PK</b>	
24D. LOCATION <b>Arbutus</b>		24E. CITY, town, or county <b>Md.</b>		24F. STATE <b>Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>Blair E. Jones</b>		25C. FUNERAL DIRECTOR <b>Morton E. Dgett Fitt</b>	
				ADDRESS <b>1701 LAURENS ST.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">52 6</span>	
BIRTH NO. <span style="float: right;">67 6284</span>		CERTIFICATE OF DEATH		67 6284	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Charles Jones</b>		2. DATE AND HOUR OF DEATH <b>6/29/67 8:15 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>16-04</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bolton Hill Nursing &amp; Convalescent Ctr.</b>		D. STREET ADDRESS (If rural, give location) <b>1808 Mosher St.</b>		E. CITY OR TOWN (If outside city limits, write RURAL and give township)	
5. SEX <b>M</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>7/17/1900</b>	9. AGE (In years lost birthday) <b>66</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hotel Handyman</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>2 15-09-5092A</b>		17. INFORMANT ADDRESS <b>James Jones 4802 Wilvan Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>4-2-2-1-1</b>		CAUSE OF DEATH (A) <b>congestive heart failure</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) <b>A.S.C.V.D.</b> DUE TO		<b>several yrs.</b>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>HYPERTROPHIC ARTERITIS.</b>		<b>sev. yrs.</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-3-66</b> 19 to <b>June 29</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>June 29</b> , 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Ellsworth Cook</b> M.D.				23B. DATE SIGNED <b>6 29-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. ELLSWORTH COOK</b>				23D. ADDRESS M.D. <b>2431 Maryland Ave. Balto 21218 Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-3-67</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Kelson Funeral Home 1345 Calhoun St.</b>			

James Jones 1887

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James Jones

1887

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6285	
BIRTH NO. 67 6285		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED Marcellus Shaw		2. DATE AND HOUR OF DEATH 6/28/67 5:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY AG			
FULL NAME OF HOSPITAL OR INSTITUTION Univ. of Md Hosp		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
		D. STREET ADDRESS (If rural, give location) Olaeta Manor Nursing Home			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH Sept. 21, 1893	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Shaw			14. MOTHER'S MAIDEN NAME Sarah		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 216-10-3787		17. INFORMANT Norman Leroy Shaw	
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 12 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/16 to 6/28 19 67, that (I) (we) last saw the deceased alive on 6/28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P.P. Toskos				23B. DATE SIGNED 6/28/67	
23C. PHYSICIAN'S NAME (Type) P.P. Toskos				23D. ADDRESS Univ. Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-67		24C. NAME OF CEMETERY OR CREMATORY BALTO. NAT'L CEM.	
24D. LOCATION BALTO. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6286</b>	
BIRTH NO. <b>67 6286</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Mary Whye</b>		2. DATE AND HOUR OF DEATH <b>6/27/67 11<sup>00</sup> A. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1403</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b> <b>1514 Division Street</b> <b>Baltimore, Maryland 21217</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>570 Presstman Street</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>May 10, 1902</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Erietta</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-22-2606</b>		17. INFORMANT <b>Roger Whye-husband</b>	
				ADDRESS <b>same</b>	
18. <b>420.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Failure</b>		CAUSE OF DEATH (A) DUE TO <b>Arteriosclerotic-Hypertensive</b> (B) DUE TO <b>Heart Disease</b> (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/23 1967</b> to <b>6/27 1967</b> , that (I) (we) last saw the deceased alive on <b>6/27 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Gilbert L. Bayfield</b> M.D.				23B. DATE SIGNED <b>6/27/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>GILBERT L. BAYFIELD</b>		23D. ADDRESS <b>722 N. Fulton Ave. Balt, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-30-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat'l. Cem.</b>	
24D. LOCATION <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Kelso Funeral Home 1348 Calhoun St.</b>			
25D. ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6287	
BIRTH NO.		67 6287		67 6287	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Mrs. GERTRUDE A. REID		2. DATE AND HOUR OF DEATH 6/27/67 11:35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND			
Church Home & Hospital		B. COUNTY HARFORD			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) JOPPA			
		D. STREET ADDRESS (If rural, give location) 1619 REID DRIVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/30/20	9. AGE (In years lost birthday) 46	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PARTTIME COOK		10B. KIND OF BUSINESS OR INDUSTRY READS DRUG CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND	
13. FATHER'S NAME CHARLES WESLEY FORREST		14. MOTHER'S MAIDEN NAME DOROTHY D. MOONEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-01-5194		17. INFORMANT DAVE R. REID SR 1619 REID DR JOPPA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EDEMA INTERVAL BETWEEN ONSET AND DEATH FEW MINUTES		CAUSE OF DEATH (A) DUE TO ISCHEMIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH SEVERAL YEARS.			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/25/67 19 to 6/27/67 19 that (I) (we) last saw the deceased alive on 6/27/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Reddy / Ortiz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/27/67	
23C. PHYSICIAN'S NAME (Type) REDDY / ORTIZ		23D. ADDRESS CHURCH HOME & HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 1, 1967		24C. NAME OF CEMETERY or CREMATORY GARDENS OF FAITH CEM	
24D. LOCATION BALTO CO MD.					
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR DIPREL BRO'S INC 7110 DELAID RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

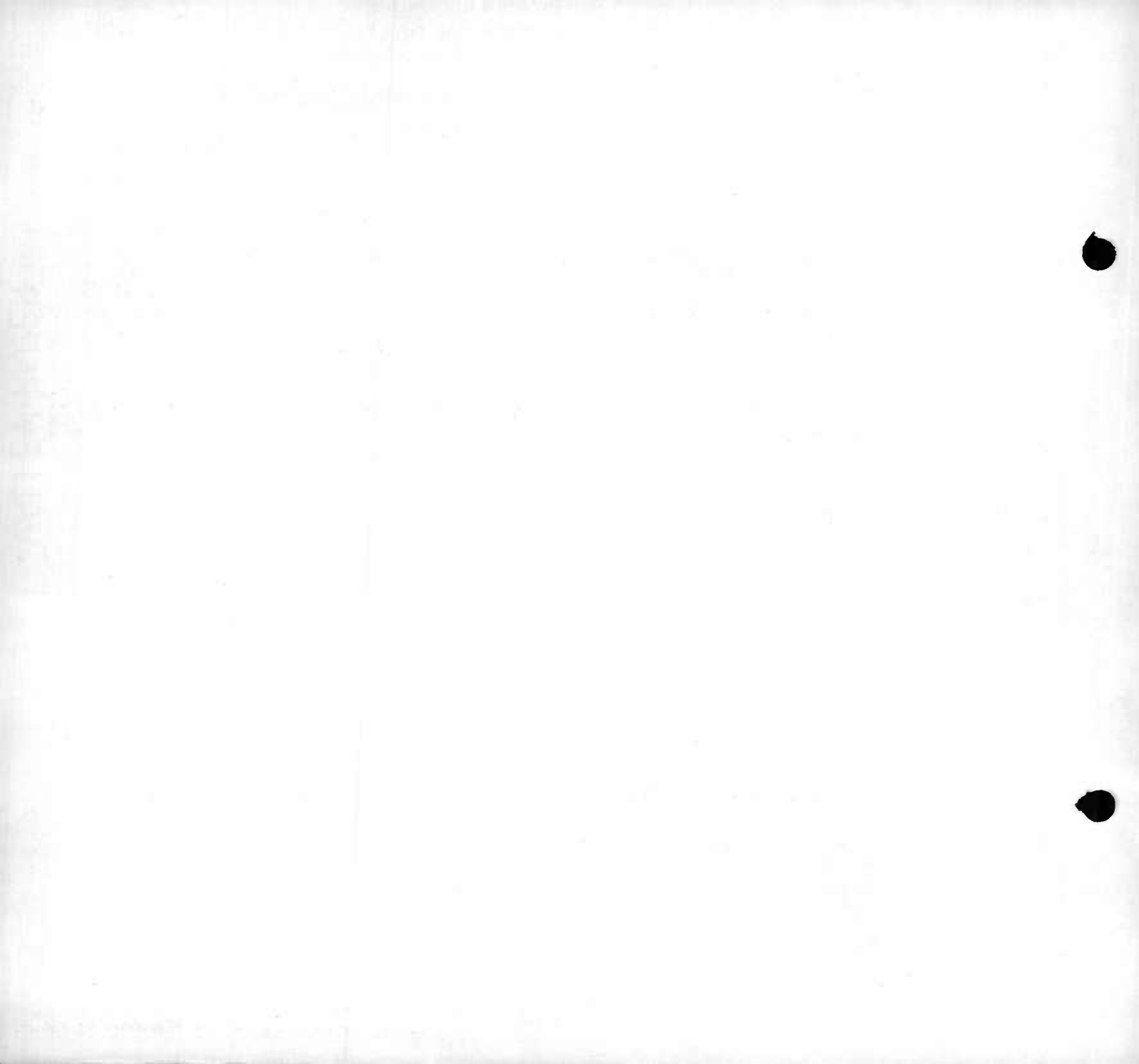
BIRTH NO. 67 6288				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6288	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		M.	
ELSIE B KNIPP				June 28, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Union Memorial Hospital				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore - 21214			
				D. STREET ADDRESS (If rural, give location)			
				2523 Hamilton Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Min.
Female	White	Widowed	Oct. 3, 1876	90			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		at Home		Baltimore, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Walter L. Beckmyer				Emma Hunter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		213-09-5924D		Mr. C. Raymond Knipp-2523 Hamilton Ave.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 1957 to June 28 1967, that (I) last saw the deceased alive on March 10 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Michael J. Dausch				June 29, 1967			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Michael J. Dausch				4636 Belair Road, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/30/67		Parkwood Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUN 30 1967		Robert E. Sander		H. Sander & Sons, Inc., Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Certificate of Death		Registered No. 67 6289	
BIRTH NO. 67 6289		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ERNEST Edwin FRANKLIN</b>		2. DATE AND HOUR OF DEATH <b>JUNE 29, 1967 7:30 PM.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1304 JAMES ST.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2102</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1304 JAMES ST.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>NOV. 17, 1903</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL Fab.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARVEY FRANKLIN</b>				14. MOTHER'S MAIDEN NAME <b>ETHEL MILLER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>MINNIE FRANKLIN 1304 JAMES ST.</b>			
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Anterior Arteriosclerotic Heart Disease 8 years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6-15</b> 19 <b>67</b> to <b>6-29</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-15</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <b>Franklin E. Leslie</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6-30-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Franklin E. Leslie</b>				23D. ADDRESS M.D. <b>302 E 33rd St - Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7-3-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>WOODLAWN</b>		24D. LOCATION (City, town, or county) (State) <b>WOODLAWN Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>600 L. Schwab Funeral Home Francis H. Miller 2101 Frederick Ave</b>			





BIRTH NO. **67 6290** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 6290**

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ELIA BROWN

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1967 11:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

309 N. Schroeder Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

309 N. Schroeder Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 31, 1890

9. AGE (in years  
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Jeremiah Stafford

14. MOTHER'S MAIDEN NAME

Hester E. Dutton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Harry W. Brown 2022 Edmondson Ave

ADDRESS

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7/2/1967

23C. NAME OF CEMETERY or CREMATORY

Arboretum Memorial Park

23D. LOCATION

Arboretum Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 30 1967

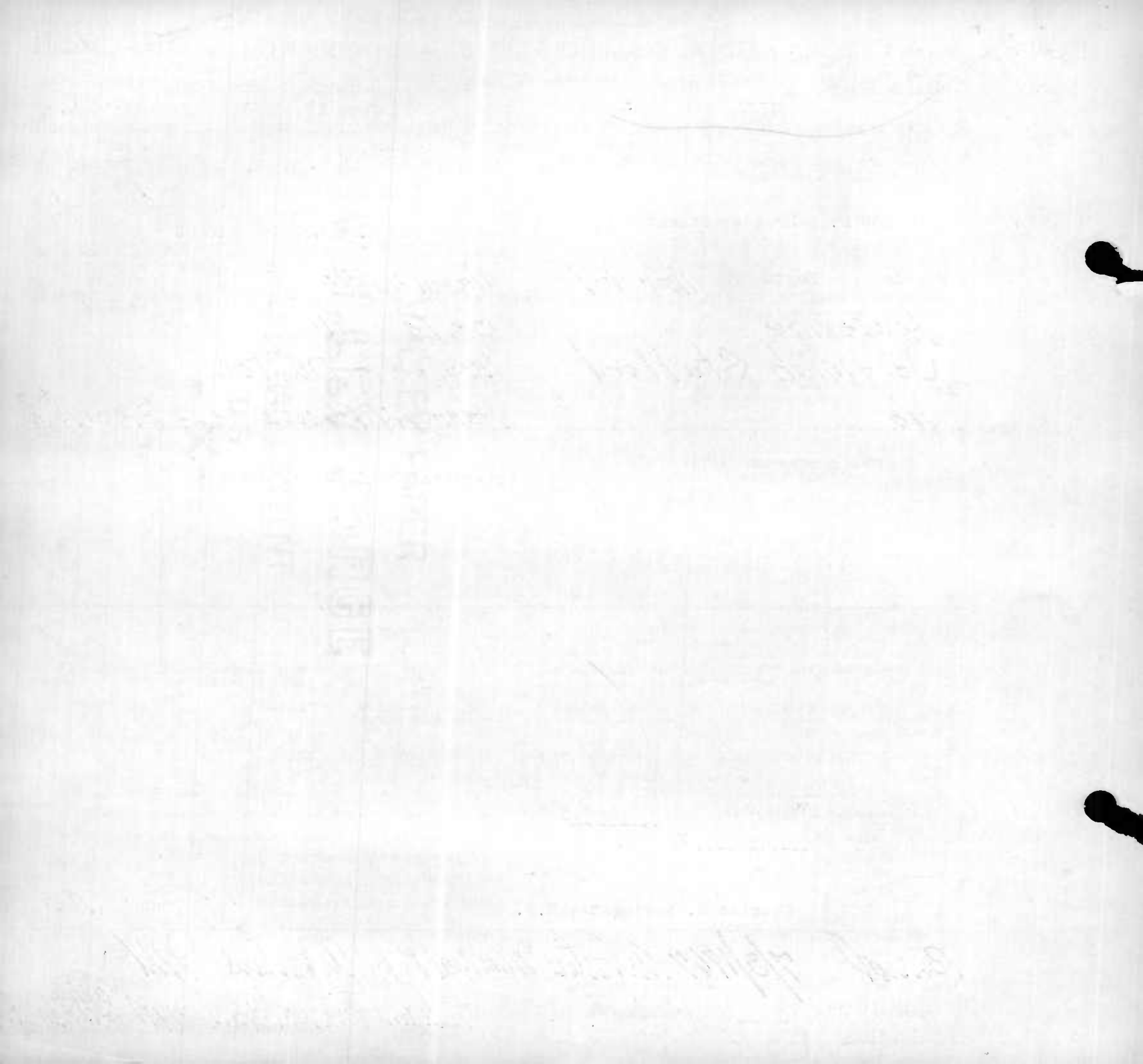
24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Schroeder St.

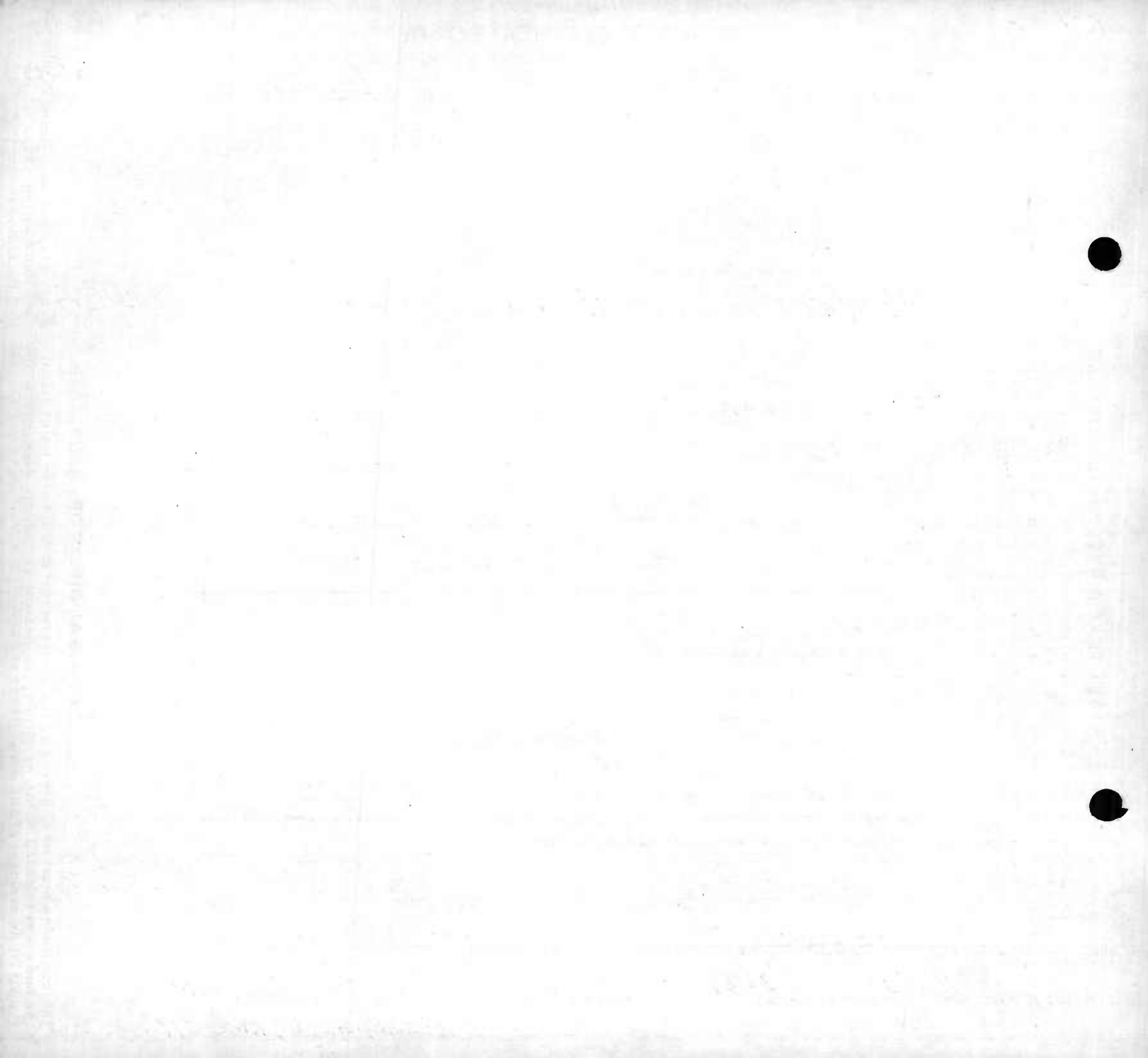
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 6291</span>	
BIRTH NO. <span style="float: right;">67 6291</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>WALTER E. ROBINSON</u>		2. DATE AND HOUR OF DEATH <u>6/27/67</u> <u>3:50</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u> <u>BALTIMORE, MARYLAND</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>16-08</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>707 EDGEMOOD STREET</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>6/1/23</u>	9. AGE (In years last birthday) <u>44</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>University Hosp</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>SAMUEL ROBINSON</u>			14. MOTHER'S MAIDEN NAME <u>JENNIE NOEL</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Korean</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>CHART</u>		
18. <u>445 X 1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>NECROTIZING ARTERIOLITIS</u> DUE TO (B) <u>MALIGNANT HYPERTENSION</u> DUE TO (C) <u>ARTERIOCLAR NEPHROSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>APRIL</u> 19 <u>66</u> to <u>PRESENT</u> 19 <u>67</u> , that <u>we</u> lost saw the deceased alive on <u>JUNE 27</u> 19 <u>67</u> and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>We</u> (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gary Plotnick</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>6/27/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Gary Plotnick</u>		23D. ADDRESS M.D. <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/3/1967</u>	24C. NAME OF CEMETERY or CREMATORY <u>Balto. National Cem. Balto. Md.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1967</u>		25B. NAME OF REGISTRAR <u>Reuben E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>	
				ADDRESS <u>319 N. Schenck St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

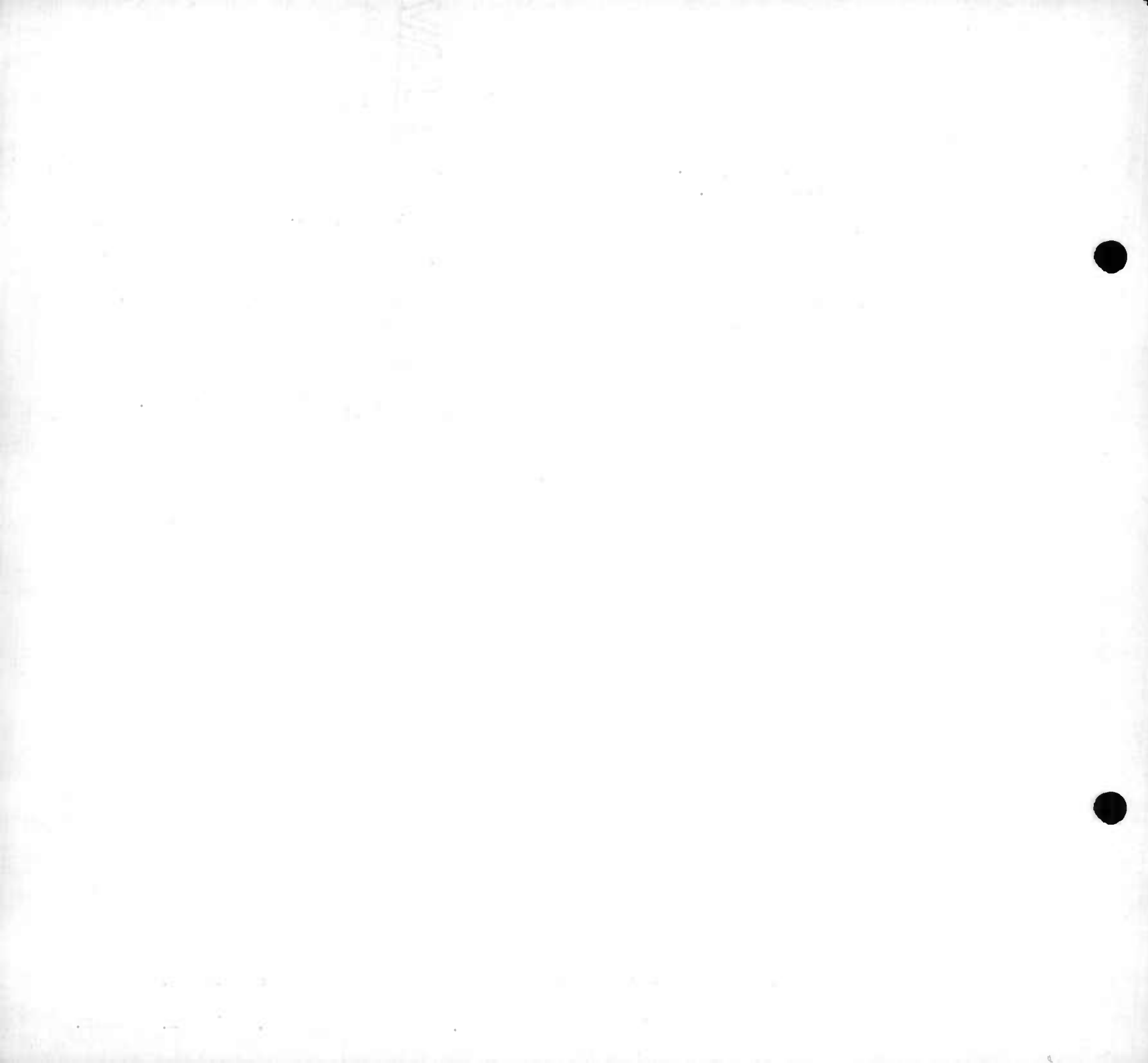
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6292</u>	
BIRTH NO. <u>67 6292</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Herman Otis Morgan</u>		2. DATE AND HOUR OF DEATH <u>JUNE 29, 1967</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1814 EUTAW PLACE</u>			
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>12-16-01</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>painter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Milke Construction</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>S</u>		14. MOTHER'S MAIDEN NAME <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>217-14-3969</u>		17. INFORMANT <u>Kenneth Koskenen</u>	
18. <u>451X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>ruptured aortic aneurysm</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>ASCVD + CHF</u>			
19A. DATE OF OPERATION <u>JUNE 26, 1967</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>aortic aneurysm</u>		20A. AUTOPSY? (Yes or No) <u>NO.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>6/26</u> 19 <u>67</u> to <u>6/29</u> 19 <u>67</u> , that (1) (we) lost saw the deceased alive on <u>6/29</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kenneth R Koskenen</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/29/67</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>3rd Gen Hospital Balto Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/3/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cox Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Cullowee Co. No. Carolina</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley MD</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook Brooks, Inc. 1217 St. Paul St.</u>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6283				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6283	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) Dora Bornheim						24 June 67 1 17:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
2502 Dulaney St. Baltimore, Md.				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		20-05	
				D. STREET ADDRESS (If rural, give location)		2502 Dulaney St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
F	W	Widowed	Sept. 17, 1890	76			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife					Virginia		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
?				?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No			217-03-3718		Donald Bornheim 2502 Dulaney St. Balto		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(A) Myocardial Infarction		1 Hr.	
				(B) Arteriosclerosis		25 yrs	
				(C) Diabetes Mellitus		10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/8 1965 to 24 June 1967, that (I) (we) last saw the deceased alive on 18 June 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
W. E. Z. Kofosse / Dr. Mess						6/24/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				Office of Dr. Christian MASS St. John's Lane E. Balto National Pike			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/29/67		Meadowridge		Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 30 1967		R. E. 2, F. J. J. J.		Wm. Cook-Brooks, Inc.		1217 St. Paul St.	

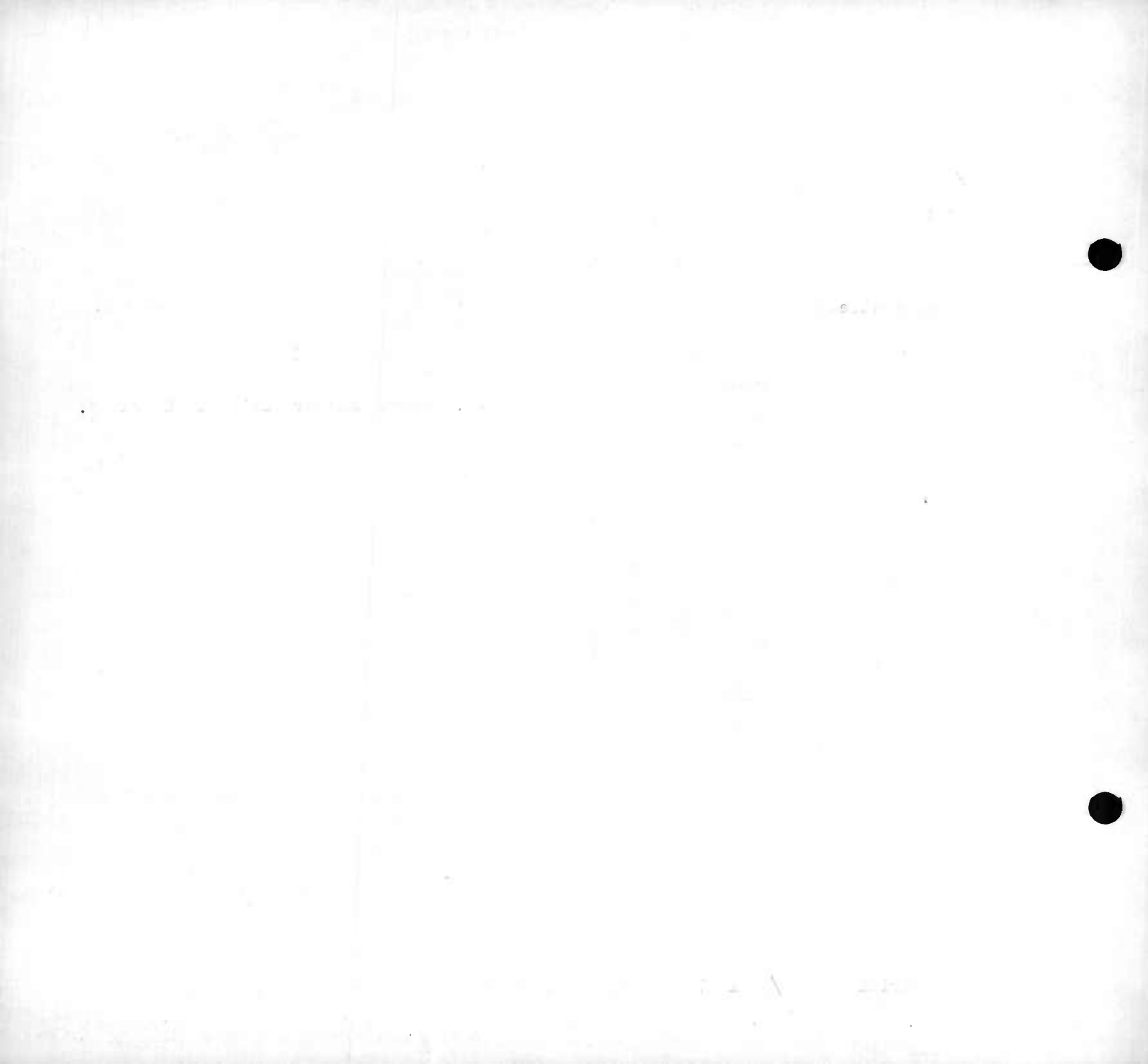




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6294				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6294	
1. NAME OF DECEASED (Type or Print) <b>HAHN, MAUDE E.</b>				2. DATE AND HOUR OF DEATH <b>28 JUNE 67 1 7 50 M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSP.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE City</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 12-01</b> D. STREET ADDRESS (If rural, give location) <b>3902 CANTERBURY RD</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>01-29-87</b>		9. AGE (In years lost birthday) <b>80</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE SCOFIELD</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA CRONK</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS <b>Mrs. Robert Waidner 1922 Old Court Rd.</b>			
18. <b>199.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>METASTATIC ADENOCARCINOMA</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>? 8 mos</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>(t)</del> (this hospital) attended the deceased from <b>03-22-67</b> 19 to <b>28 JUNE 67</b> , that <del>(t)</del> (we) last saw the deceased alive on <b>28 JUNE</b> 19 <b>67</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(t)</del> (We) (did <del>not</del> ) view the body after death.							
23A. SIGNATURE <b>Sidney E. Kuntley</b> M.D.				23B. DATE SIGNED <b>28 JUNE 67</b>		23C. PHYSICIAN'S NAME (Type) <b>Sidney E. Kuntley</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/30/1967</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenmount Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jankins</b>		25C. FUNERAL DIRECTOR <b>Wm. F. Tidmore &amp; Sons</b>		25D. ADDRESS <b>Baltimore, Md.</b>	



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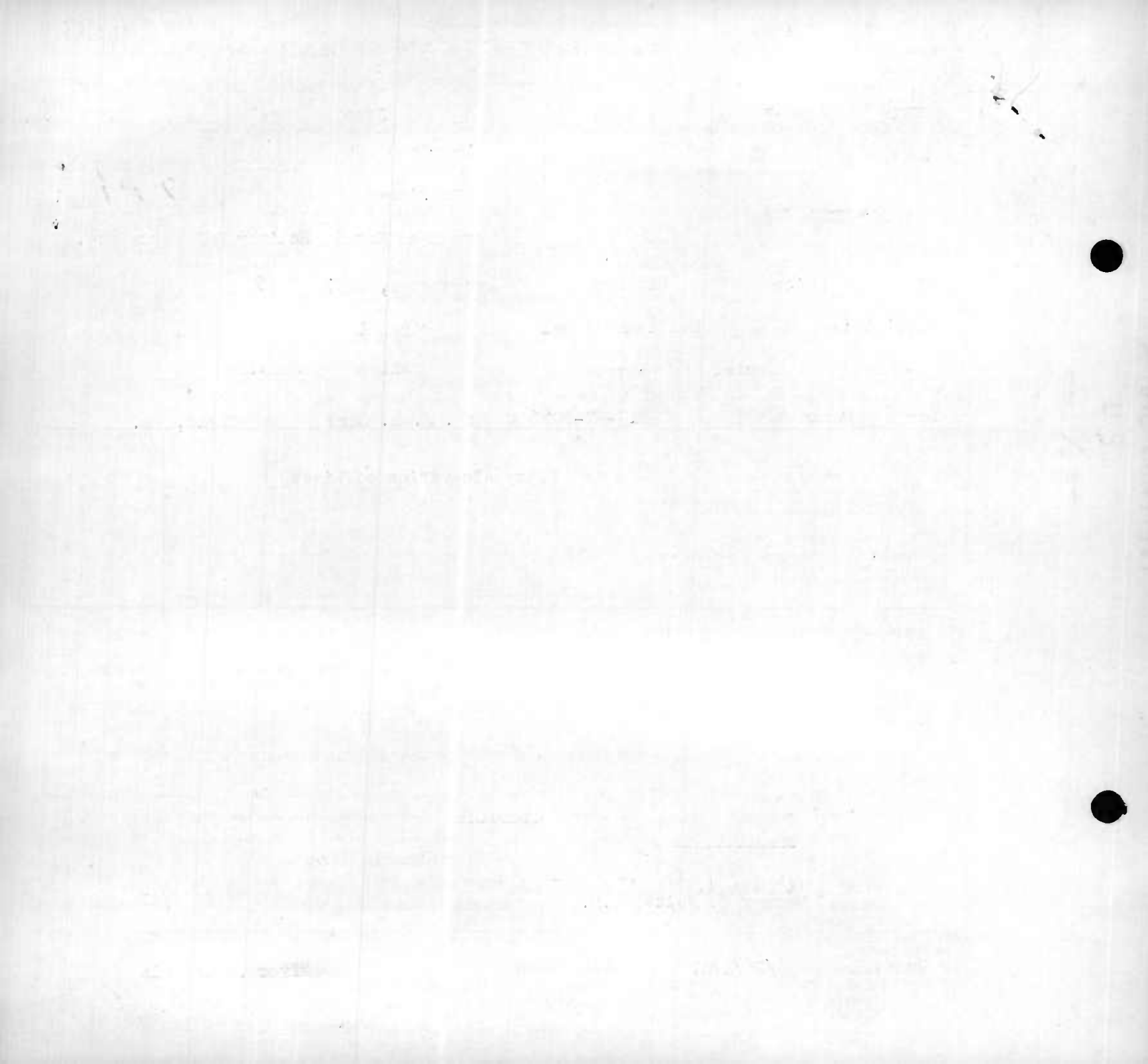
67 6295 BALTIMORE CITY HEALTH DEPARTMENT 67 6295

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_  
M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>PHILIP Arthur WARREN</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>June 24, 1967 11:35 AM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MERCY HOSPITAL (DCA)</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) _____ <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) _____ <b>Armstead Hotel, Holiday &amp; Fayette Sts.</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>December 3, 1897</b> AGE (In years last birthday) <b>69</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
13. FATHER'S NAME <b>Thomas Daniel Warren</b>		14. MOTHER'S MAIDEN NAME <b>Alice Chapman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>213-07-2986 A</b>	
		17. INFORMANT ADDRESS <b>Mrs. J. E. Eure Warefield, Va.</b>	
18. <b>381.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Fatty Alteration of Liver</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) _____ DUE TO _____ (B) _____ DUE TO _____ (C) _____  INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>6/25/67</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>	23B. DATE <b>6/26/1967</b>	23C. NAME of CEMETERY or CREMATORY <b>Mill Swamp</b>	23D. LOCATION (City, town, or county) (State) <b>Ivori, Virginia</b>
24A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>	24B. NAME OF REGISTRAR <b>Robert E. Spitz</b>	24C. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Chapman &amp; Son, 101 N. 1st St., Baltimore, Md.</b>	

VS 151-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6296</b>	
BIRTH NO. <b>67 6296</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MARGARET A. WILL</b>			
2. DATE AND HOUR OF DEATH <b>6/29/67 3:10 P.M.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Mayland General Hosp</b>		(If not in hospital or institution, give street address or location)			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>1012 N. Ives St.</b>		26-44			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>4/10/12</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Harry Owens</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kegg</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>175-20-2263</b>		17. INFORMANT <b>daughter</b>	
18. <b>420.1 I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>Possible coronary thrombosis (sudden death)</b>		<b>sudden</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>Arteriosclerotic heart dis.</b>		<b>few yrs</b>	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Amputation left leg, mid thigh due to art. and venous obstructions</b>		<b>Renal insufficiency</b>	
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? Yes or No <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6/7</b> 19 <b>67</b> to <b>6/29</b> 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>6/29</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ronald Goldner</b>		M.D.	Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>6/29/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>RONALD GOLDNER</b>		M.D.	23D. ADDRESS <b>527 Linden Ave.</b>		
24A. BURIAL CREMATION REMOVAL (Specify) <b>REMOVAL</b>	24B. DATE <b>6-30-67</b>	24C. NAME of CEMETERY or CREMATORY <b>GRAND VIEW</b>		24D. LOCATION (City, town, or county) (State) <b>JOHNSTOWN PA.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones, M.D.</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Fickner &amp; Sons, Balt. Md.</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 6297		Registered No. 67 6297	
BIRTH NO.		67 6297		<b>CERTIFICATE OF DEATH</b>		Registered No. 67 6297	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BERTHA G. CONEN</b>		2. DATE AND HOUR OF DEATH <b>6-28-67 7:45 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3 THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>VIRGINIA</b> B. COUNTY <b>NORFOLK</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>V-4/3</b> D. STREET ADDRESS (If rural, give location) <b>7320 GLENROLE AVE.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <del>WIDOWED</del> <b>WIDOWED</b>	8. DATE OF BIRTH <b>4-6-05</b>	9. AGE (In years lost birthday) <b>62</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Norfolk, Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>MOSES A. GLASSER</b>		14. MOTHER'S MAIDEN NAME <b>RACHAEL SALSBERG</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Oliver Funeral Home</b>		ADDRESS <b>1501 Colonial Ave.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>GRAM NEGATIVE SEPSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>UTI</b> <b>ADENOCARCINOMA OF BOWEL OR OVARY</b> INTERVAL BETWEEN ONSET AND DEATH <b>24hr.</b> <b>? 24hr +</b> <b>at least 8 mo</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>MAY 19 1967</b> to <b>JUNE 28 1967</b> , that (we) lost saw the deceased alive on <b>JUNE 28 1967</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Daniel C. Hadlock M.D.</b>				23B. DATE SIGNED <b>6-28-67</b>			
23C. PHYSICIAN'S NAME (Type) <b>DANIEL C. HADLOCK M.D.</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>6/29/1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>Forest Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Norfolk, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm. F. Pickens &amp; Sons</b>		ADDRESS <b>Baltimore north 2nd ave.</b>	

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67 6298

BALTIMORE CITY HEALTH DEPARTMENT

67 6298

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)JAMES ~~Manson~~ ~~Baron~~ Batchelder

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1967 8:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

821 Mc Kim Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

821 Mc Kim Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 8, 1883

9. AGE (In years  
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

?

Batchelder

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

Unk.

17. INFORMANT

Mrs. Lillian Batchelder

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7/3/67.

23C. NAME of CEMETERY or CREMATORY

Western Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 30 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

WALLACE R. SCOTT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 6299		67 6299	
CERTIFICATE OF DEATH				Registered No.			
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Hacker, Walter Alexander, Jr.		June 29, 1967 8:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Union Memorial Hospital 33rd & Calvert Sts. Balto. 21218				Maryland (21213) C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-03 D. STREET ADDRESS (If rural, give location) 3341 Cliftonmont Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
M	W	Married	July 13, 1909	59			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?		
A. S. Abell (Sun Papers) Supt.			Maryland		U. S. A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Walter Hacker				Carrie Woody			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Yes W W 2			Unk.		Mrs. Lillian A. Hacker (3341 Cliftonmont Ave)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
18. I				Status post resection of carcinoma of rectum - 5 weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO acute pyelonephritis - bilateral Ca. of rectosigmoid (B) DUE TO acute bronchopneumonia, bilateral (C) No Necrosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
5-22-1967		Ca. of colon		Yes		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 5, 1967 to June 29, 1967 that (I) (we) lost saw the deceased alive on June 29, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Sang-Kyun Shim M.D.				6/29/67.			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
SANG-KYUN SHIM				Union Mem. Hosp. 33rd & Calvert Sts.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/3/67.		Loudon Park Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 30 1967		Robert E. Farley, M.D.		Leonard J. Ruck, Inc. Balto. Md. 21214			

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Clermont

Mr. William A. Hackett  
Carrie Moody

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A. 2. April (also paper)  
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67 6300		BALTIMORE CITY HEALTH DEPARTMENT		67 6300	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
HOWARD H. SCHMALBACH		June 28, 1967 5:30 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland			
UNION MEMORIAL HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21213			
		D. STREET ADDRESS (If rural, give location) 3421 Shannon Drive			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	White	Married	January 17, 1898.	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Concessionaire				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry Schmalbach		Anna Doll		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WW 1 213-09-9236		Mrs. Arlyne C. Schmalbach (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Arteriosclerotic Heart Disease					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER			
Russell S. Fisher, M.D.		ASSOCIATE MEDICAL EXAMINER			
23A. BURIAL, CREMATION, REMOVAL, Entombment		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		7/1/67.		Lorraine Park Mausoleum	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JUN 30 1967		Robert E. Fisher		Leonard J. Ruck, Inc. Balto. Md. 21214	

WILLIAM MORRIS

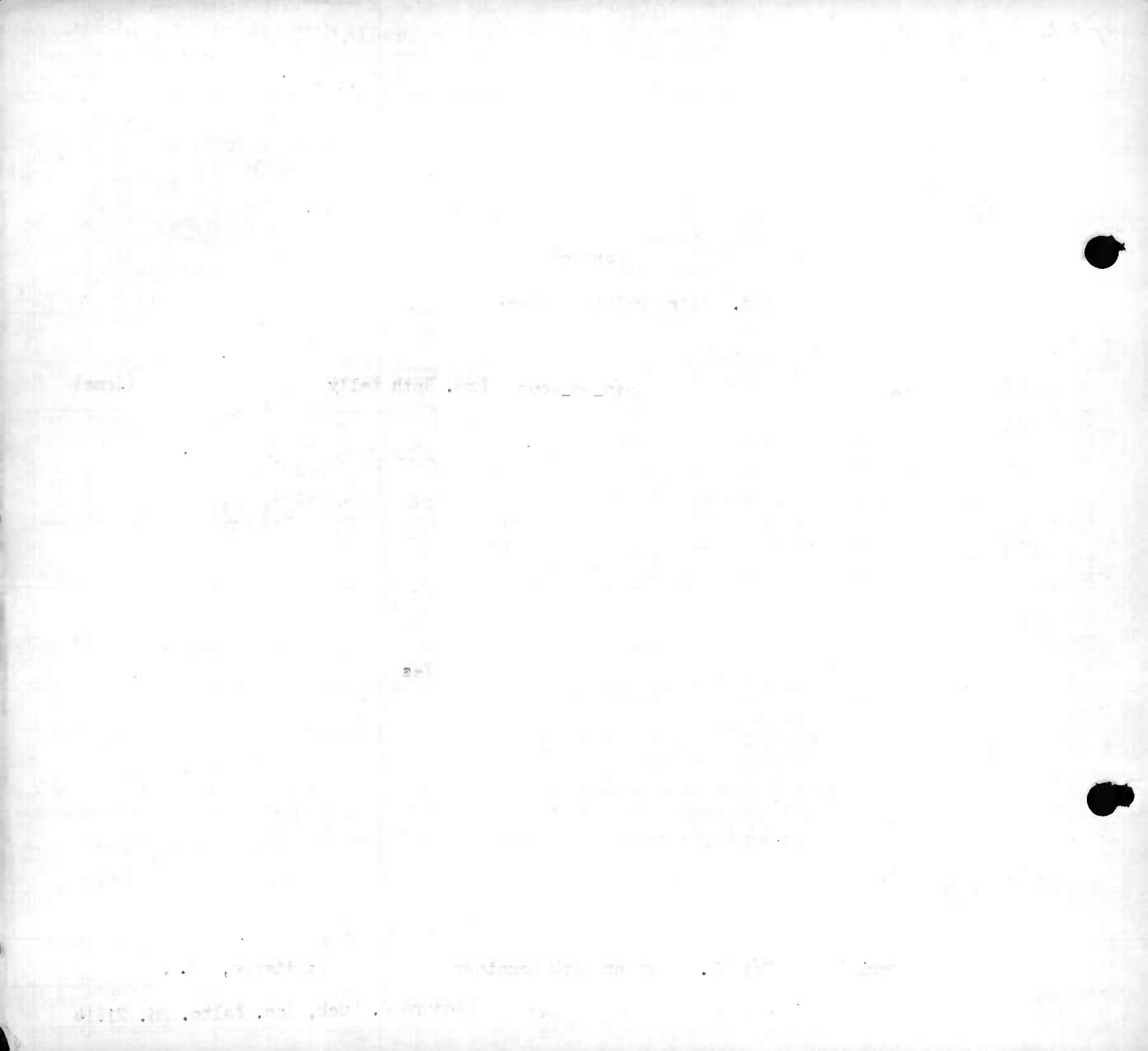
1861-1896

Faint, illegible text covering the page, likely bleed-through from the reverse side.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6301	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 67 6301</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>HUGH KELLY</u>			<b>2. DATE AND HOUR OF DEATH</b> <u>6/28/67</u> <u>11:30</u> P.M.		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>7 MERCY HOSPITAL</u>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Balto</u> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <u>BALTIMORE 21234</u> <b>D. STREET ADDRESS</b> (If rural, give location) <u>5300 2412 TAYLOR AVE</u>		
<b>5. SEX</b> <u>m</u>	<b>6. RACE</b> <u>w</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>11/26/08</u>	<b>9. AGE</b> (In years lost birthday) <u>58</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>STOREKEEPER (Md. State Training School)</u>			<b>11. BIRTHPLACE</b> (State or foreign country) <u>WEST Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>PATRICK KELLY</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>FLORENCE HURST</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-07-2973</u>	<b>17. INFORMANT</b> <u>Mrs. Ruth Kelly</u>		<b>ADDRESS</b> <u>(Same)</u>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I</u> <b>CAUSE OF DEATH</b> (A) DUE TO <u>Acute myocardial infarction</u> (B) DUE TO <u>Pulmonary embolism</u> (C) <u>ABCD</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b> <u>2</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>Yes</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>6/28</u> <u>19 67</u> <b>to</b> <u>6/28</u> <u>19 67</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>6/28</u> <u>19 67</u> <b>and that in (my) (our) opinion death occurred on the date</b> <u>6/28</u> <u>19 67</u> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Barry Ominsky</u> M.D.				<b>23B. DATE SIGNED</b> <u>6/28/67</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Barry Ominsky</u>		<b>23D. ADDRESS</b> <u>MERCY HOSPITAL</u>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>7/1/67</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JUN 30 1967</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>			

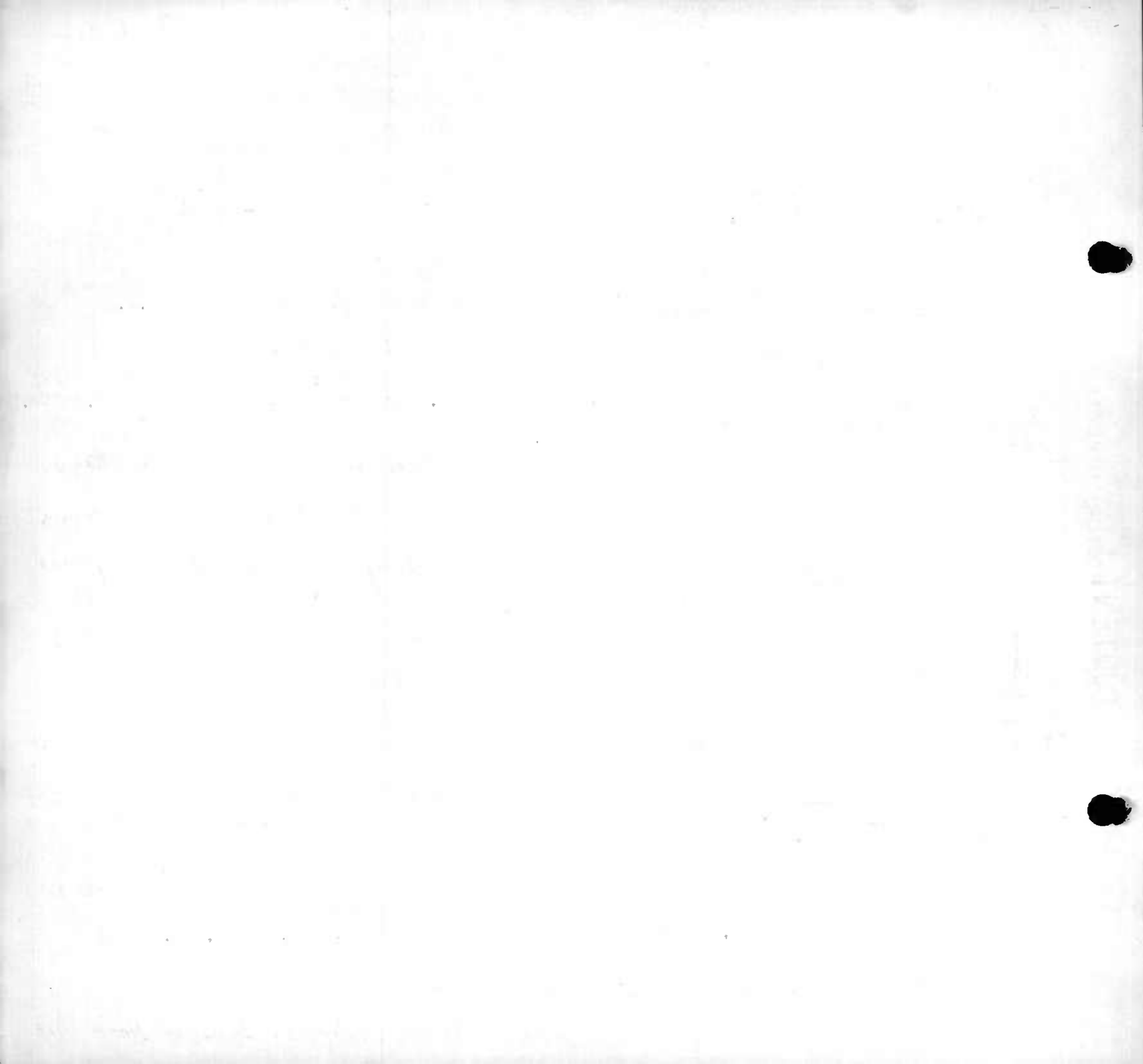




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

40-93-21		67 6302		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6302	
BIRTH NO.							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <b>JAMES M. BELL</b>				2. DATE AND HOUR OF DEATH <b>JUNE 29, 1967 7:15 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>26-12</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>4940 Eastern Avenue - 21224</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>		8. DATE OF BIRTH <b>1/14/36</b>	9. AGE (In years last birthday) <b>31</b>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock-Check</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN STORES</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND (BALTIMORE)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>BENJAMIN BELL</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET WILLIAMS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-34-9620</b>		17. INFORMANT RECORDS: ADDRESS <b>21224</b> <b>Balto. City Hospitals, 4940 Eastern Ave. Balto. Md.</b>			
18. <b>722.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Bacteremia</b> DUE TO (B) <b>Multiple decubiti</b> DUE TO (C) <b>Antibiotic spondylitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b> <b>cutaneous.</b> <b>10 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>Psoriasis.</b>		<b>8 years -</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>2/18</b> 19 <b>66</b> to <b>6/29</b> 19 <b>67</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>6/27</b> 19 <b>67</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>D. Tarsy</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-29-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>D. Tarsy</b>		23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue, Balto. Md. 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7/3/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>WESTERN STAR CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>CATONSVILLE BALTO CO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>HERBERT E. NUTTER</b>		ADDRESS <b>3035 W. NORTH AVE</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 6303		67 6303	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MOSES MARY			6-29-67 12-10 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland.			A. STATE Maryland		
			B. COUNTY 15-06		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2826 W. North Ave		
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-27-1911	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10B. KIND OF BUSINESS OR INDUSTRY Saint Joseph Laundry - Amersonville N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Will Tyson			14. MOTHER'S MAIDEN NAME Eliza Little		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Lawrence Pegues-1616 N. Ellamont St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260X I CAUSE OF DEATH (A) Cardiovascular accident (B) Diabetes mellitus (C) A.S.C.V.D.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) O	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-8-1967 to 6-29-1967, that (I) (we) lost saw the deceased alive on 6-29-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anil M. Joshi			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI			23D. ADDRESS Lutheran Hospital of Maryland, 730 Ashburton St. Baltimore 21216		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/67		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Nutter Funeral Home - 3035 W. North Ave.	



1  
D-450

67 6304

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6304

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MAUDE DELANEY

2. DATE AND HOUR PRONOUNCED DEAD

6-26-67

9:50 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

813 N. Calhoun Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Oct. 26, 1895

9. AGE (In years  
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Amelia Co. Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

? ? ? ?

14. MOTHER'S MAIDEN NAME

? ? ? ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Nicholas Delaney-813 N. Calhoun Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL  
SIGNATURE

*Russell S. Fisher*

M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

6-26-67

EXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/30/67

23C. NAME OF CEMETERY or CREMATORY

Family Lot  
Chester Grove Cemetery

23D. LOCATION

(City, town, or county)

(State)

Amelia Co. Virginia

24A. DATE REC'D BY HEALTH DEPT.

JUN 30 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

ADDRESS

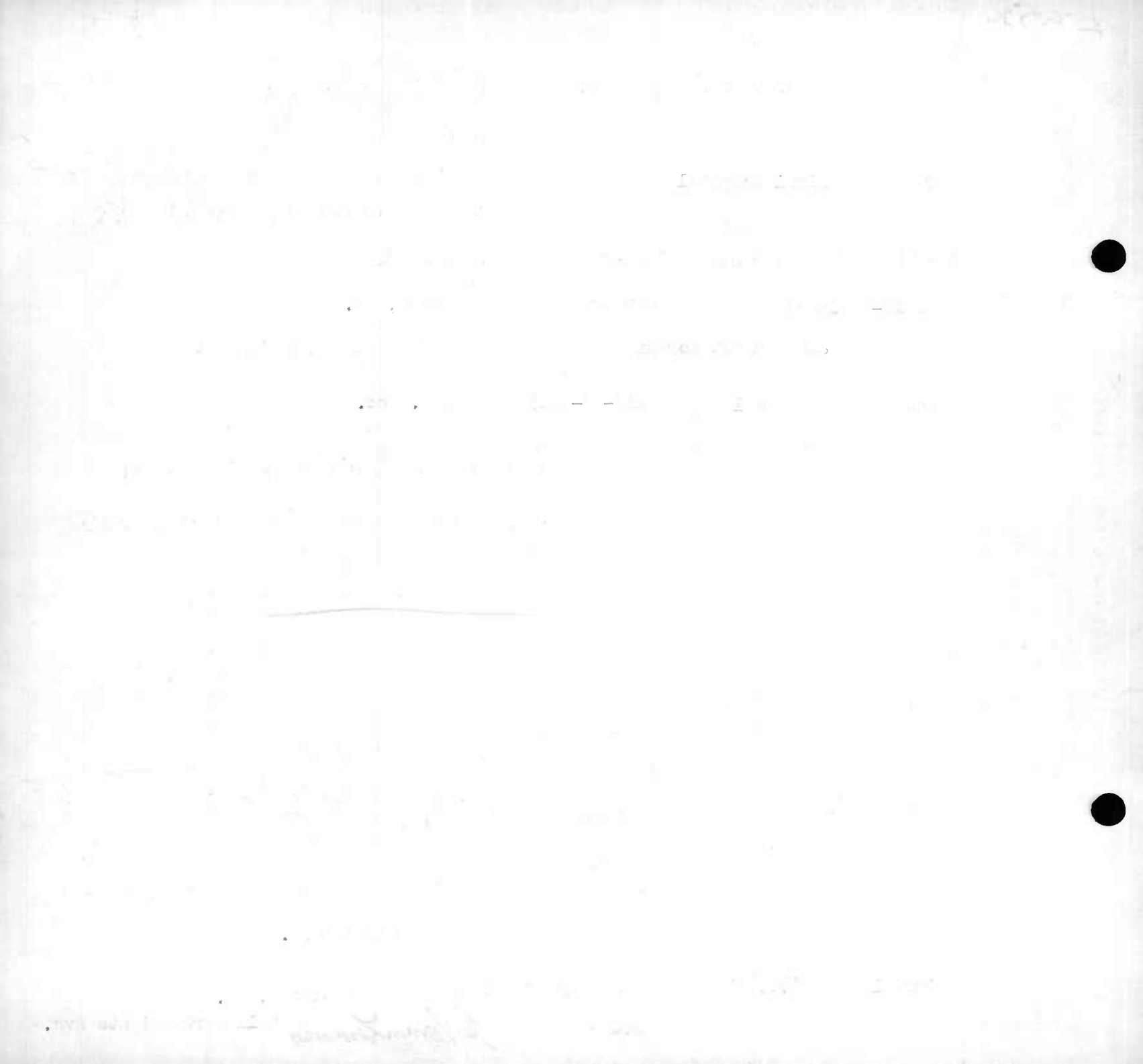
Herbert E. Nutter-3035 W. North Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 6305 CERTIFICATE OF DEATH					Registered No. 67 6305					
BIRTH NO. 67 6305					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>LORENZ, August</b>					2. DATE AND HOUR OF DEATH <b>6/29/67 1355 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>Siani Hospital</b>					A. STATE <b>MD</b>					
					B. COUNTY					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE CITY 13-13</b>					D. STREET ADDRESS (If rural, give location) <b>4504 REISTERSTOWN RD</b>					
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widower</b>	8. DATE OF BIRTH <b>12/26/92</b>	9. AGE (In years last birthday) <b>74</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John August Lorenz</b>			14. MOTHER'S MAIDEN NAME <b>Agatha Siegwart</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W # 1</b>			16. SOCIAL SECURITY NO. <b>216-09-5025</b>		17. INFORMANT ADDRESS <b>Hosp. Rec.</b>					
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL VASCULAR ACCIDENT</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>					INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>6/28</b> 19 <b>67</b> to <b>6/29</b> 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>6/29</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>James S. Lee</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>6/29/67</b>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS <b>Sinai Hosp.</b>					
24A. BURIAL-CREATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>7/3/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 30 1967</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>Le. Vernon L. Loman</b>			ADDRESS <b>4611 Park Heights Ave.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6306				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6306	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <b>CLETUS A. ELLIS</b>				2. DATE AND HOUR OF DEATH <b>6-29-67 6:00 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<b>CHURCH HOME AND HOSPITAL</b>				<b>MARYLAND</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				<b>BALTIMORE</b>		<b>24-01</b>	
				D. STREET ADDRESS (If rural, give location)			
				<b>1443 TOWSON ST.</b>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
<b>MALE</b>	<b>WHITE</b>	<b>DIVORCED</b>	<b>5-27-04</b>	<b>63</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Tally Keeper</b>		<b>STEAMSHIP</b>		<b>MARYLAND</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>PATRICK ELLIS</b>				<b>CATHERINE LOGAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
<b>NO</b>		<b>088-05-6138</b>		<b>Katherine Smith 1810 Northbourne Rd.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)							
19A. CAUSE OF DEATH							
(A) <b>UREMIA</b>				<b>YEARS</b>			
(B) <b>CHRONIC NEPHRITIS</b>				<b>YEARS</b>			
(C)							
19B. ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that <del>(by)</del> (this hospital) attended the deceased from <b>6-19-1967</b> to <b>6-29-1967</b> , that (I) (we) last saw the deceased alive on <b>6-28-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
<b>Francisco Baltazar</b>						<b>6/29/67</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
<b>FRANCISCO BALTAZAR</b>				<b>CHURCH HOME &amp; HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>7/3/67</b>		<b>New Catholic Cemetery</b>		<b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<b>JUN 30 1967</b>		<b>Robert E. Sanborn</b>		<b>Charles E. Stevens Funeral Home, Inc.</b>		<b>1501 E. Fort Avenue</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 67. 6307				
BIRTH NO. 67-1346967 6307					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Baby Boy HART					2. DATE AND HOUR OF DEATH 6/27/67 3 30 PM M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital					A. STATE Maryland B. COUNTY Carroll				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) FINKSBURG 56-00				
					D. STREET ADDRESS (If rural, give location) Hillendale Ct.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) N/A	8. DATE OF BIRTH 6/26/67	9. AGE (In years lost birthday) 1	10. If Under 1 Yr. Months 1	11. If Under 24 Hrs. Days 12	12. If Under 24 Hrs. Hours 12	13. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A			10B. KIND OF BUSINESS OR INDUSTRY N/A			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DALE HART					14. MOTHER'S MAIDEN NAME MARY HART				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. 433.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
ANTECEDENT CAUSES					(A) DUE TO Cardiac Arrest				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					(B) DUE TO Respiratory disease				
					(C) Fetal distress before delivery				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					None				
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 6/26 1967 to 6/27 1967, that (I) (we) last saw the deceased alive on 6/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE James B. Brayton M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 6/27/67				
23C. PHYSICIAN'S NAME (Type) James B. Brayton M.D.					23D. ADDRESS The Johns Hopkins Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 6-28-67		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS HOSPITAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1967			25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL				

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6308	
BIRTH NO.		67 6308		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Adam H. Degele		7-1-1967 4:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
6026 Mannington Avenue #6		Md.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore 26-01			
		D. STREET ADDRESS (If rural, give location)			
		6026 Mannington Avenue 21206			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days Hours Min.
Male	White	Married	6-29-1900	67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Self-employed		Overhead Doors		Baltimore City Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles Degele			Minnie Richert		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		577-03-7783		Mrs Alberta Degele 6026 Mannington Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Myocardial Infarction (B) DUE TO Chronic Myocarditis (C) Chronic Pulmonary Emphysema			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1 1967 to July 1 1967, that (I) (we) last saw the deceased alive on June 30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles E. Campbell				23B. DATE SIGNED 7/1/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7-5-1967		Parkwood Cemetery	
				Baltimore, Ms.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 3 1967		Robert E. Fairbank		Lassahn Funeral Home 7401 Belair Rd.	

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Handwritten text, possibly a date or a short note, located at the bottom of the page.

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>1-620</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 6309</u>	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <u>Joseph Allen Norris</u>		
2. DATE AND HOUR OF DEATH <u>6/30/67</u> <u>2:30 A.M.</u>			3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Maryland</u>		
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
D. STREET ADDRESS (If rural, give location) <u>1411 Argyle Ave.</u> <u>21217</u> <u>007</u>			14-02		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-7-11</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman (Retired)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Merchant Ship</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Norris</u>		14. MOTHER'S MAIDEN NAME <u>Grace Johnson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-01-4456</u>		17. INFORMANT <u>BCH: Records 4940 Eastern Ave. Baltimore, Md.</u>	
18. <u>10-57-01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>? PULM. EMB</u> DUE TO (B) <u>BEDFASTNESS D/K HEPATOMA</u> DUE TO (C) <u>~ 8 mos.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>? 4 hrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/8/</u> 19 <u>67</u> to <u>6/30</u> 19 <u>67</u> , that <u>(I)</u> (we) last saw the deceased alive on <u>6/29/67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stewart Leibowitz</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>6/30/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Stewart Leibowitz</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Maryland #21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>6/30/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus mem. PK.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Am. Ch. Chaturman</u>		25D. ADDRESS <u>1701 M.E. Cullen St. Baltimore, Md.</u>	

James (John) Macdonald  
Glasgow

1850

1850

1850

James Macdonald

1850

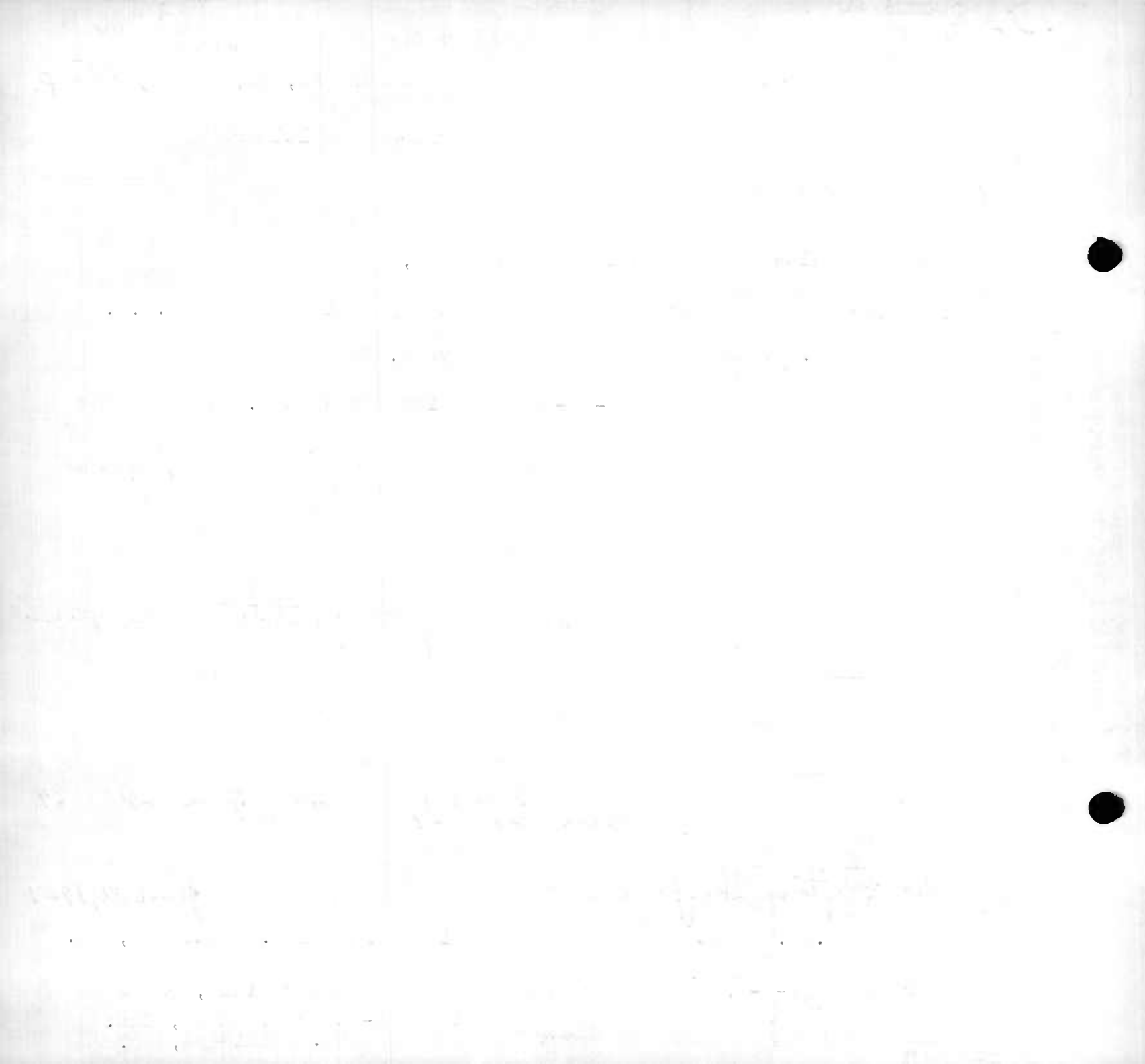
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

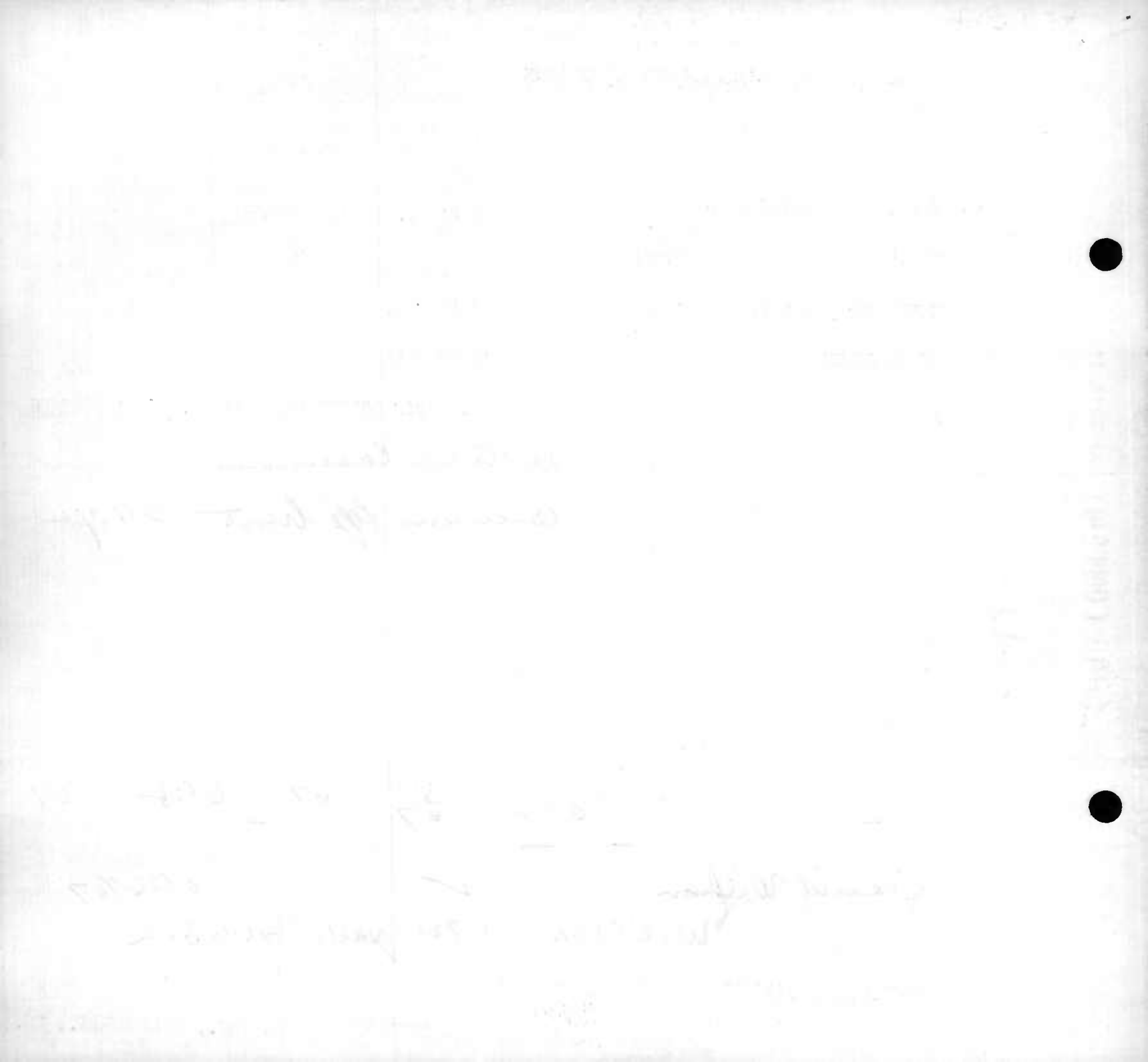
BALTIMORE CITY HEALTH DEPARTMENT									
67 6310					Registered No. 67 6310				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
JOHN EVANS					June 28, 1967 6:15 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HDSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  90 Long Green Home					A. STATE Maryland				
					B. COUNTY Baltimore				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00				
					D. STREET ADDRESS (If rural, give location) 321 Regester Avenue				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
Male	White	Married		July 13, 1878	88				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Doctor		Xray		Pennsylvania		U.S.A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
John G. Evans					Eva M. Knabb				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
					218-40-0688		A Miss Margaret K. Evans Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury at complication which caused death.)  450.01-172X Arteriosclerosis (generalized)					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH 1 year				
II					Carcinoma of the prostate				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					3 1/2 years				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from June 29 1964 to June 28 1967, that (I) (we) last saw the deceased alive on June 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
W. Grafton Hersperger M.D.					June 30, 1967				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Dr. W. Grafton Hersperger M.D.					Medical Arts Bldg. Baltimore, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		7-1-67		Druid Ridge		Pikesville, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS					
JUL 3 1967		Robert E. Fisher, Jr.		Mitchell-Wiedefeld Home, Inc.		6500 York Rd. Baltimore, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6311		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6311	
BIRTH NO.		M.E. CASE NO.		PAULINE RUTH GOLDSTEIN	
1. NAME OF DECEASED (Type in full)		2. DATE AND HOUR OF DEATH		June 28th 1967 6:25 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
BELVEDERE NURSING HOME		BALTIMORE		13-01	
D. STREET ADDRESS (If rural, give location)		2228 MT. ROYAL TERRACE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days Hours Min.
FEMALE	WHITE	MARRIED		65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
USA		HYMAN COHEN		LIBBY VELLIN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		UNKNOWN		MR. DAVID GOLDSTEIN, 2228 MT. ROYAL TERRACE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Metastatic Carcinoma			
		(B) DUE TO Carcinoma left breast		> 4 yrs	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3 1967 to 6/28 1967, that (I) (we) last saw the deceased alive on 6/28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Daniel Wilfson				6/28/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
WILFSON		5721 Park Heights Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		6/30/67		BETH EL MEMORIAL PARK	
24D. LOCATION (City, town, or county)		24E. NAME of REGISTRAR		24F. FUNERAL DIRECTOR	
RANDALLSTOWN, MARYLAND		Robert E. Finkbeiner		SOL LEVINSON & BROS. INC., 6010 REIST., RD.	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 8 1967		Robert E. Finkbeiner		SOL LEVINSON & BROS. INC., 6010 REIST., RD.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6312		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6312	
1. NAME OF DECEASED (Type or Print) <i>Richardson, MAY</i>				2. DATE AND HOUR OF DEATH <i>6/30/67 3:50 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BAITIMORE</i>			
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i>				6. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BAITIMORE</i>			
7. D. STREET ADDRESS (If rural, give location) <i>700 W 40<sup>th</sup> ST.</i>				8. DATE OF BIRTH <i>5-7-1890</i>			
9. SEX <i>FEMALE</i>		10. RACE <i>white</i>		11. AGE (In years last birthday) <i>77</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Armstrong, James.</i>		14. MOTHER'S MAIDEN NAME <i>Ford, Frances</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO.</i>		16. SOCIAL SECURITY NO. <i>216-32-9775</i>	
17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of <del>stomach</del> colon</i>		18. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		19. INTERVAL BETWEEN ONSET AND DEATH <i>UNKNOWN</i>		20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Heart Disease - Atherosclerotic</i>	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		22. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Heart Disease - Atherosclerotic</i>					
23. DATE OF OPERATION <i>6/22/67</i>		24. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Pelvic mass</i>		25. AUTOPSY? (Yes or No) <i>NO</i>		26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>NO</i>		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		30. HOW DID INJURY OCCUR?	
31. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		32. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		33. I certify that (I) (this hospital) attended the deceased from <i>6/19</i> 19 <i>67</i> to <i>6/30</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6/30</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		34. DATE SIGNED <i>6/30/67</i>	
35. PHYSICIAN'S NAME (Type) <i>JAMES L. ALLEN</i>		36. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>		37. DATE OF CREMATION <i>July 3/67</i>		38. DATE OF REMOVAL (Specify)	
39. NAME OF CEMETERY OR CREMATORY <i>Louisa Park</i>		40. LOCATION (City, town, or county) (State) <i>Balto - 21229</i>		41. DATE RECEIVED BY HEALTH DEPT. <i>JUL 3 1967</i>		42. NAME OF REGISTRAR <i>E. F. F. F.</i>	
43. FUNERAL DIRECTOR <i>Stewart</i>		44. ADDRESS <i>108 W. North</i>		45. DATE OF DEATH <i>6/30/67</i>		46. TIME OF DEATH <i>3:50 A.M.</i>	

2000-10-10

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67 6313

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6313

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or print)  
HOWARD

LEE

BAKER

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1967

1:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Bon Secour Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

529 S. Monroe Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 10, 1938

9. AGE (in years  
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Reggie

10B. KIND OF BUSINESS OR INDUSTRY

The Dry dock

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles A. Baker

14. MOTHER'S MAIDEN NAME

Erma Laisure

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

216-32-0180

17. INFORMANT

Carol Baker - 529 S. Monroe St.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Massive Internal Bleeding  
DUE TO Gunshot Wound of Neck

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

In rear of 440 S. Smallwood Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
June 30, '67 12:35  
A. m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot as result of an argument

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREWerner U. Spitz, M.D.  
EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/30/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7/3/67

23C. NAME of CEMETERY or CREMATORY

London Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 3 1967

24B. NAME OF REGISTRAR

Robert E. Feltz

24C. FUNERAL DIRECTOR

John J. Cowan - Sr. Inc. 901 Hollins St.

24D. ADDRESS

Baltimore, Md.

VALLEY HARBOR

MAIL DELIVERY POINT

DEPARTMENT OF

INDUSTRY



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6314				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6314	
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>Mary Victoria DeSantis</u>				<b>2. DATE AND HOUR OF DEATH</b> <u>JUNE 26, 1967</u>   <u>3</u> <u>A.</u> M.			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>339 S. Conkling Street</u>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <u>Baltimore</u> <b>D. STREET ADDRESS</b> (If rural, give location) <u>339 S. Conkling Street</u>			
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>7/2/1895</u>	<b>9. AGE</b> (In years lost birthday) <u>71</u>	<b>10. UNDER 1 Yr.</b> Months _____ Days _____	<b>11. UNDER 24 Hrs.</b> Hours _____ Min. _____	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Business</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Tavern</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Fernando Gallo</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>unk.</u>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> ADDRESS <u>Mr. Frank DeSantis</u>			
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 45%;"> <b>(A) DUE TO</b> <u>Coronary Occlusion</u>  <b>(B) DUE TO</b> <u>Diabetic Mellitus</u>  <b>(C)</b> _____                 </div> </div>							<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>							
<b>19A. DATE OF OPERATION</b> <u>6/21</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>January 1955</u> <b>to</b> <u>June 26</u> <b>19</b> <u>67</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>6/21</u> <b>19</b> <u>67</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <u>Joseph R. Liberto</u> M.D.					<b>23B. DATE SIGNED</b> <u>6/28/67</u>		
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>JOSEPH R. LIBERTO</u> M.D.				<b>23D. ADDRESS</b> <u>3508 BARK ST. Baltimore, Md 21224</u>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Entombment</u>		<b>24B. DATE</b> <u>6/29/67</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Lorraine Park</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JUL 3 1967</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Tarkenton</u>		<b>25C. FUNERAL DIRECTOR</b> ADDRESS <u>Joseph N. Zannino 263 S. Conkling S</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6315		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6315	
M.E. CASE NO.		FLORENCE ZINK		DATE AND HOUR OF DEATH JUNE 29, 1967 9:15 P.M.	
1. NAME OF DECEASED (Type or Print)		FLORENCE ZINK		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		MARYLAND	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	
8. DATE OF BIRTH 1/15/75		9. AGE (In years lost birthday) 92		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK Moeslein	
14. MOTHER'S MAIDEN NAME OTILIA Goldbeck		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-54-0060	
17. INFORMANT RECORDS: BALTIMORE CITY HOSPITALS, Balto. Md. 21224		18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Cerebrovascular		Unknown	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19C. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4-17-1967 to 6-29-1967, that (I) lost saw the deceased alive on 6-29-1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.		23A. SIGNATURE D. TARSY		23B. DATE SIGNED 6/29/67	
23C. PHYSICIAN'S NAME (Type) D. TARSY		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224		23E. FUNERAL DIRECTOR Joseph J. Zannini	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/3/67		24C. NAME of CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Belair Rd		24E. DATE REC'D BY HEALTH DEPT. JUL 3 1967		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. ADDRESS 2635 S. Conkling		24H. ADDRESS		24I. ADDRESS	

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 6316</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 6316</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Samuel <del>XXXXXXXXXX</del> OKUN</b>		2. DATE AND HOUR OF DEATH <b>6-28-67 5:15 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>Levin Dale Hebrew Home &amp; Infirmary</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LEVINDALE AGED HOME</b>		(If not in hospital or institution, give street address or location)			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>1888</b>	9. AGE (In years lost birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
13. FATHER'S NAME <b>YESHA OKUN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>A 219-10-1847</b>		17. INFORMANT <b>MR. JOSEPH OKUN, 4007 BANCROFT ROAD #15</b>	
18. <b>491X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-28-58</b> 19 to <b>6-28-1967</b> , that (I) (we) last saw the deceased alive on <b>6-28-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ardaiz</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-28-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jose ARDAIZ</b>		23D. ADDRESS M.D. <b>5912 Cross Country Blvd. Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/29/67</b>		24C. NAME of CEMETERY or CREMATORY <b>BETH ISAAC ADATH ISRAEL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REIST. RD.</b>	

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BIRTH NO. **67 6317** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 6317**

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)**Bernard  
JOSEPH MARX**

2. DATE AND HOUR PRONOUNCED DEAD

**June 29, 1967 12:15 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

**Baltimore City Hospital (DOA)**4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**3515 Kenyon Avenue**

5. SEX

**Male**

6. RACE

**White**7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)**married**

8. DATE OF BIRTH

**Oct. 13, 1906**9. AGE (In years  
last birthday)**60**If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Roofer**

10B. KIND OF BUSINESS OR INDUSTRY

**self-employed**

11. BIRTHPLACE (State or foreign country)

**Baltimore, Md.**12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

**Michael Marx**

14. MOTHER'S MAIDEN NAME

**Dora Fisher**15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)**no**16. SOCIAL  
SECURITY NO.**214-01-6827**

17. INFORMANT

ADDRESS

**Marie Donnellan Marx, wife, above**

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **Cerebrocranial injuries**  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

**Yes**20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?**Yes**21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)**patio**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

**419 N. Highland Avenue**21D. TIME OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)**6-29-67 11:59 A.**

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

**Fell off roof**

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)**Charles S. Springate, M.D.**CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

**June 29, 1967**23A. BURIAL CREMATION,  
REMOVAL (Specify)**Burial**

23B. DATE

**7/3/67**

23C. NAME of CEMETERY or CREMATORY

**Holy Redeemer Cemetery**

23D. LOCATION (City, town, or county) (State)

**Baltimore, Md.**

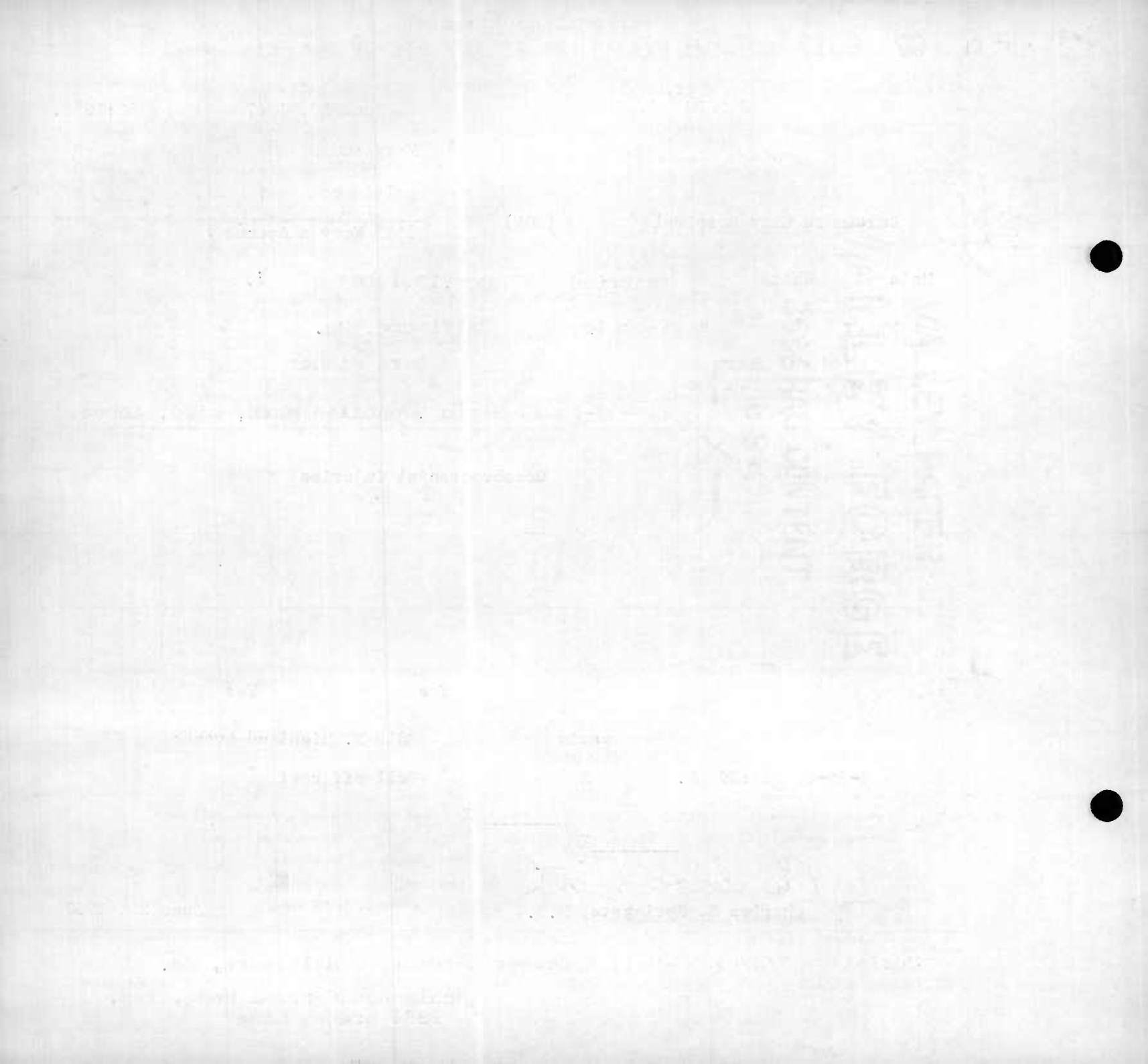
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

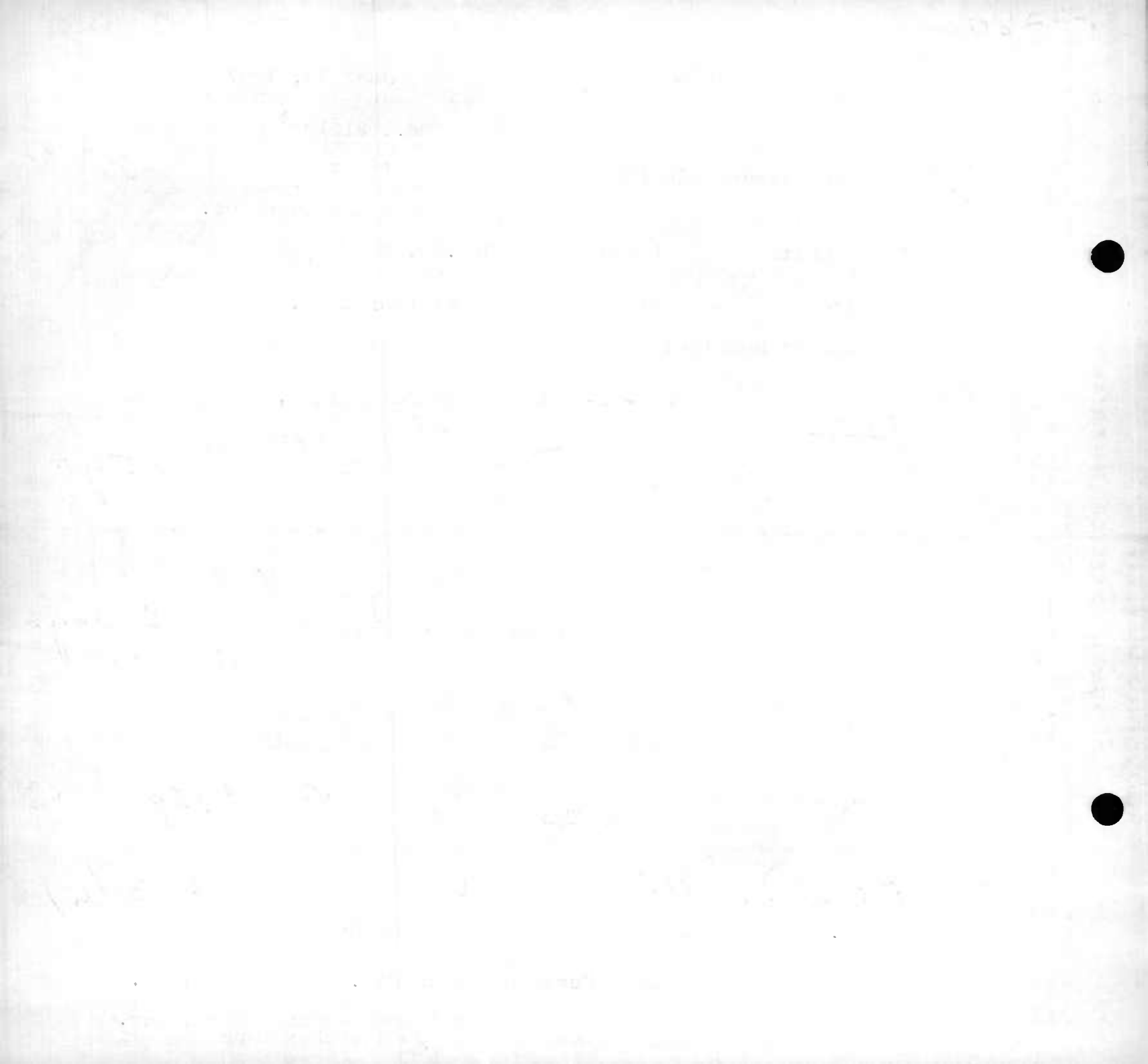
**JUL 3 1967****Robert E. Farber****Schimunek Funeral Home, Inc.  
3331 Brehms Lane**





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6318	
BIRTH NO. 67 6318		CERTIFICATE OF DEATH		Registered No. 67 6318	
1. NAME OF DECEASED (Type or Print) ANNA FISHER			2. DATE AND HOUR OF DEATH June 29, 1967		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md., 21213 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3524 Cardenas Ave.		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Dec. 30, 1888	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months Days 10. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Frances Bocklage			14. MOTHER'S MAIDEN NAME Margaret Ortt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 214-01-4376D		16. SOCIAL SECURITY NO. 214-01-4376D	17. INFORMANT Margaret Fisher, dght, above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Myocarditis (Chronic) (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 15 yr	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/30/67 to 6/29/67 that (I) (we) last saw the deceased alive on 6/29/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel Miller			23B. DATE SIGNED 6/30/67		
23C. PHYSICIAN'S NAME (Type) Dr. Daniel Miller			23D. ADDRESS 4321 Harford Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/67		24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus Cem. Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 6319</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 6319</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>EDNA L. KALB</b>			2. DATE AND HOUR OF DEATH <b>June 29, 1967</b> <b>10<sup>05</sup> P M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3321 Kentucky Ave. Baltimore, Md., 21213</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>  D. STREET ADDRESS (If rural, give location) <b>3321 Kentucky Avenue</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>1/13/96</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>William H. Joyce</b>			14. MOTHER'S MAIDEN NAME <b>Martha Young</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-30-2385</b>		17. INFORMANT ADDRESS <b>Mrs. Janis Keffer, dght. above</b>	
18. <b>154X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma Rectum</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Carcinoma Rectum</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>Feb. 1967</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma Rectum</b>		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>February 1967</b> to <b>June 29 1967</b> , that (I) (we) last saw the deceased alive on <b>June 29 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Karl F. Mech, M.D.</b>				23B. DATE SIGNED <b>6/29/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Karl F. Mech</b>			23D. ADDRESS <b>3350 Wilkens Avenue</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/3/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>	



W-655

BIRTH NO. 67 6320

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6320

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM WEHRMAN

2. DATE AND HOUR PRONOUNCED DEAD

June 28, 1967

6:55 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3400 E. Northern Parkway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3400 E. Northern Parkway

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 8, 1903

9. AGE (in years  
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Wehrman

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

213-09-2788

17. INFORMANT

ADDRESS

Hazel E. Wehrman-3400 Northern Parkway-21206

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-3-67

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 3 1967

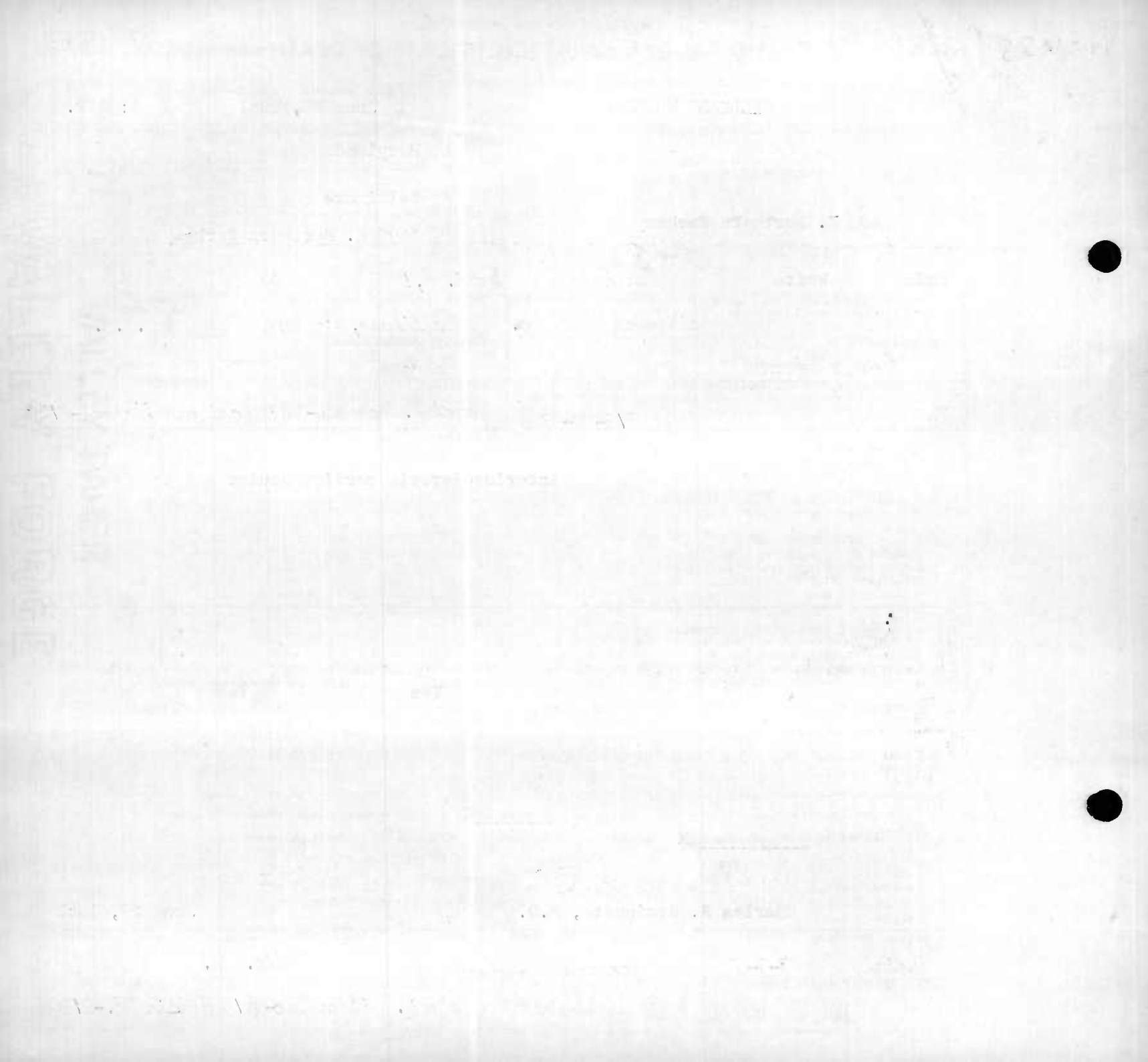
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

John C. Miller Inc-6415 Belair Rd.-21206

ADDRESS



1  
W-452

67 6321

BALTIMORE CITY HEALTH DEPARTMENT

67 6321

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LELA F. WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1967

12:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7943 Lansdale Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

APR. 22 1893

9. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM SCHROCK

14. MOTHER'S MAIDEN NAME

EMMA MILLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

HOSP. RECORDS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic  
cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE, OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

6

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

REMOVAL

23B. DATE

7/1/67

23C. NAME of CEMETERY or CREMATORY

BAYARD

23D. LOCATION (City, town, or county) (State)

BAYARD W. VA

24A. DATE REC'D BY HEALTH DEPT.

JUL 3 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

CONNELLY SONS

ADDRESS

300 MACE

LEIGHTON DURST OAKLAND MD

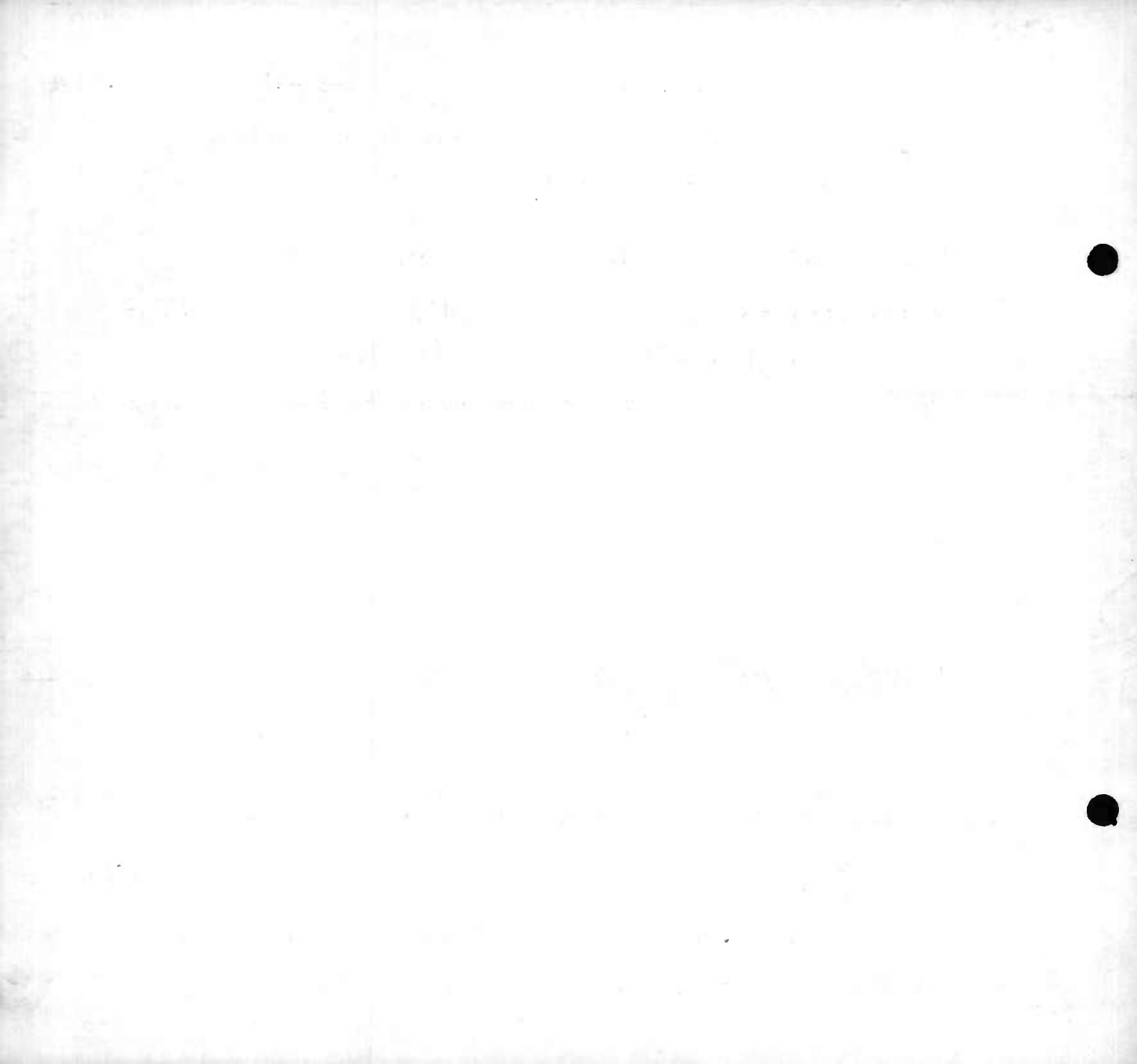
WILEY FOREST  
LEAFLET  
INSTRUMENT



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6322				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6322	
M.E. CASE NO.				WALTER L. PICKETT		DATE AND HOUR OF DEATH 6-30-67	
1. NAME OF DECEASED (Type or Print)						3.10 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND			
				B. COUNTY BALTIMORE			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 913 VIRGINIA AVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 3-18-07	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ARTHUR PICKETT				14. MOTHER'S MAIDEN NAME IDA FILES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 215-03-3778		17. INFORMANT HELEN PICKETT		ADDRESS ABOVE	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <i>Massive pulmonary embolus</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION 6/28/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary Emboli		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>6/28</u> 19 <u>67</u> to <u>6/30</u> 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>6/30</u> 19 <u>63</u> and that in my <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <i>William B. Iams</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/30/67	
23C. PHYSICIAN'S NAME (Type) WILLIAM B. IAMS				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/3/67		24C. NAME of CEMETERY or CREMATORY DULANEY VALLEY		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1967		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR J.E. CONNELLY SONS		ADDRESS 300 MACE	



## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Florence Verner King

2. DATE AND HOUR OF DEATH

6/29/67

8:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals  
4940 Eastern Ave.  
Baltimore, Maryland # 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md. Baltimore

D. STREET ADDRESS (If rural, give location)

401 Mace Avenue 21221 005

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Divorced

8. DATE OF BIRTH

3-10-1902

9. AGE (In years  
last birthday)

65

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Baltimore Co. Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Eugene Stansbury

14. MOTHER'S MAIDEN NAME

Caroline Biehler

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

B.C.H. Records 4940 Eastern Ave. 21224

18. 170X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) CA breast, disseminated  
DUE TOINTERVAL BETWEEN  
ONSET AND DEATH

1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/15 1967 to 6/29 1967, that (I) (we) last saw the deceased alive on 6-29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Franklin G. Straus

M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

6/29/67

23C. PHYSICIAN'S NAME (Type)

Franklin G. Straus

M.D.

23D. ADDRESS

BCH

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-3-1967

24C. NAME OF CEMETERY or CREMATORY

Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 3 1967

25B. NAME OF REGISTRAR

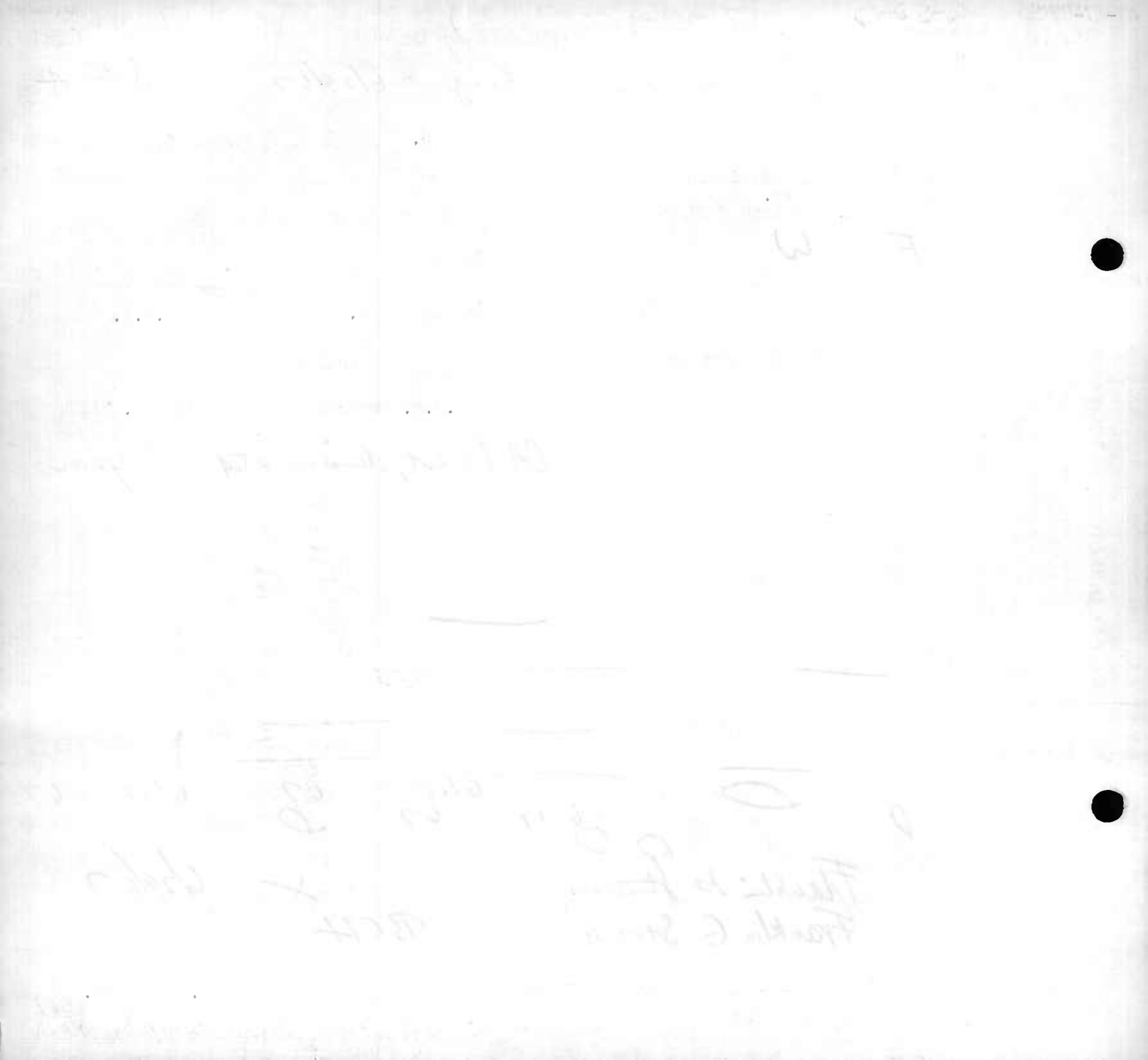
Robert E. Farber

25C. FUNERAL DIRECTOR

Lansbury Funeral Home 7401 Belair Road

FUNERAL DIRECTOR: IMPORTANT

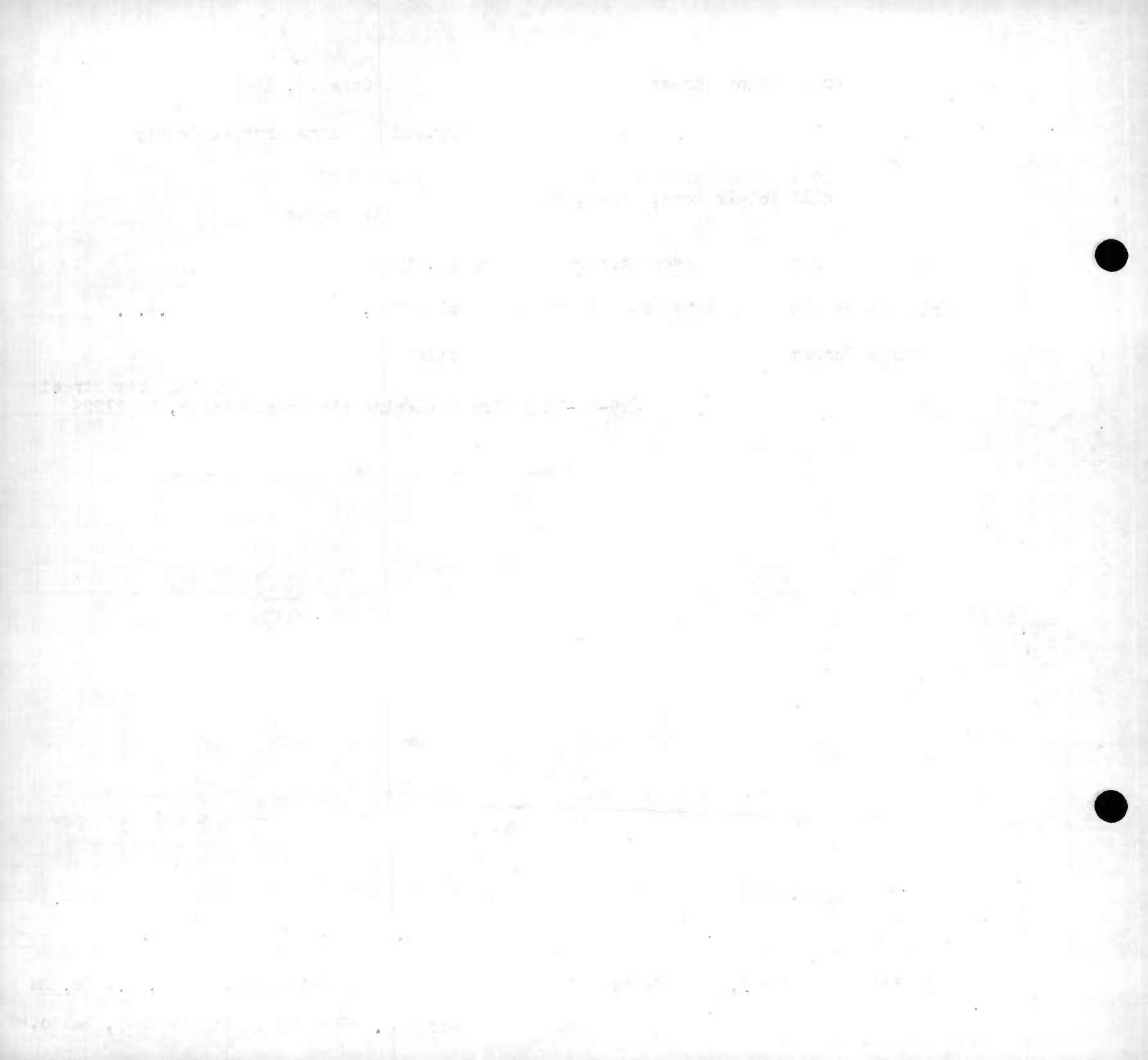
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

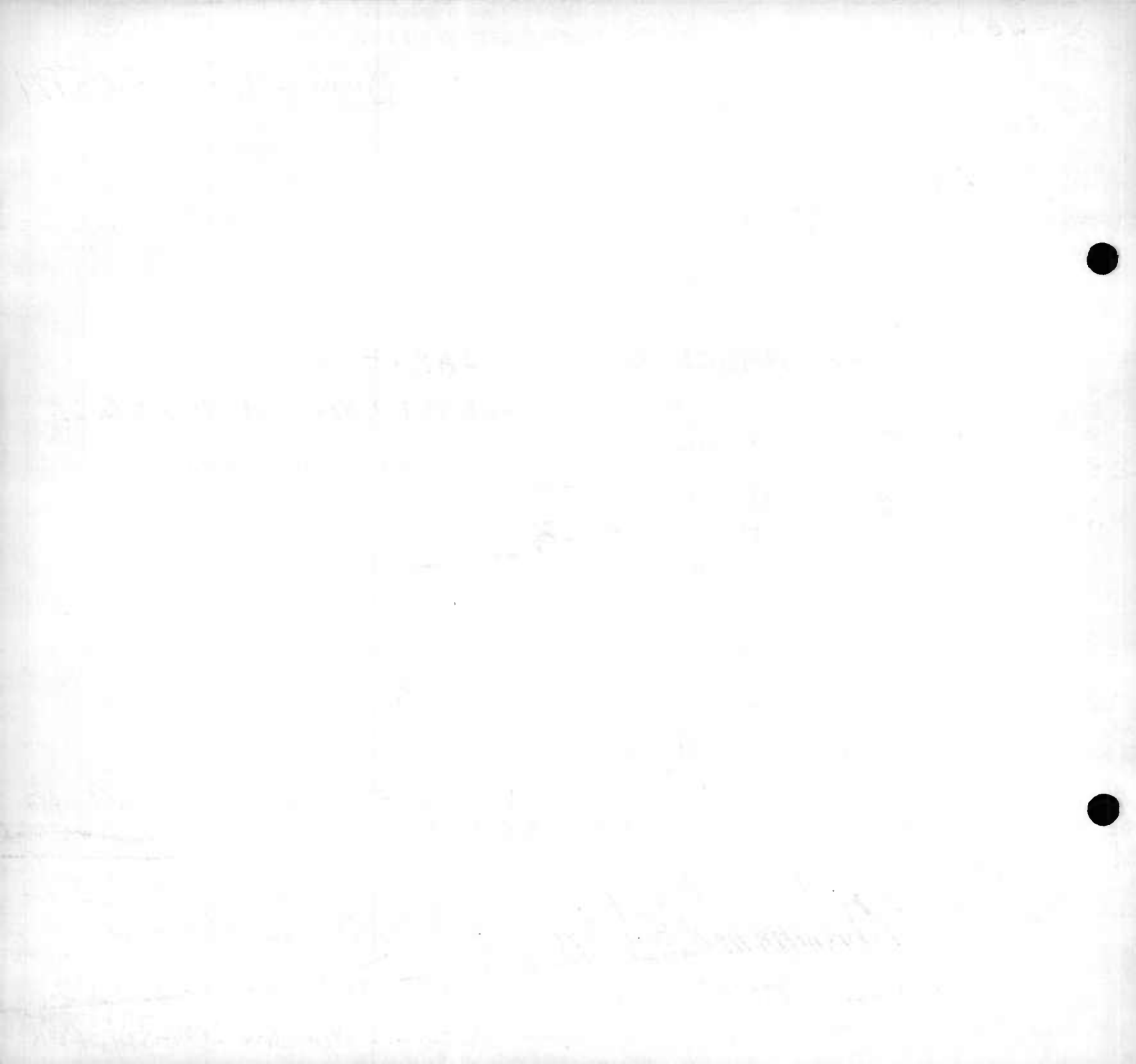
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6324	
BIRTH NO. 67 6324		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Norman LeRoy Thomas</b>			2. DATE AND HOUR OF DEATH <b>June 28, 1967 9:50 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Gould Convalescent Home 6116 Belair Road, Balto, Md</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel County</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21225</b> D. STREET ADDRESS (If rural, give location) <b>215 Doris Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>Cauc</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>May 13, 1905</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Anne Arundel County</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>George Thomas</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>219-01-2183</b>		
			17. INFORMANT ADDRESS <b>407 Jeffrey Street</b> <b>Mrs Katherine Richardson Balto, Md 21225</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of left lung associated Cerebral thrombosis &amp; phlebitis</b>			CAUSE OF DEATH <b>Terminal uremia</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b>			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Fibroid Non Reactive Tuberculosis</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 23, 1967</b> to <b>June 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 27, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H.V. Harbold</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>June 28, 1967</b>
23C. PHYSICIAN'S NAME (Type) <b>HARBOLD</b>			23D. ADDRESS <b>4706 HARFORD Rd-14 Baltimore, Md</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 1, 1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Ritchie Hgwy, Balto, A.A Co, Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George J. Gonce 4001 Ritchie Hgwy, Balto, Md</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6325</b>	
67 6325				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>ANNA KRAUSCH</b>		2. DATE AND HOUR OF DEATH <b>June 29/67 6:05 PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>1517 Cole Street</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>8-25-80</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jones SAMUEL TROTT</b>			14. MOTHER'S MAIDEN NAME <b>SARAH JONES</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>ERNEST J. KRAUSCH</b>		ADDRESS <b>1517 Cole St.</b>
18. <b>430.01 + 260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized atherosclerosis</b> <b>Partial pulm. atelectasis</b> <b>Diab. mellitus</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 25 1967</b> to <b>June 29 1967</b> that (I) (we) last saw the deceased alive on <b>June 29/1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. M. Ghiladi</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>June 29/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Abdolhamid Ghiladi</b>		23D. ADDRESS <b>Bon Secours Hospital</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>7-3-67</b>	24C. NAME OF CEMETERY or CREMATORY <b>LOUDON PARK CEMET.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>WALTERS FUNERAL HOME</b>	
				ADDRESS <b>PRATT &amp; STRICKER STS.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6326					Registered No. 67 6326				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
DONAHOE, JOHN JOSEPH					JULY 2, 1967 9:20A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
ST. AGNES HOSPITAL					A. STATE B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					MARYLAND 21207				
WILKENS & CATON AVES.					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
BALTO., MD. 21229					BALTIMORE				
					D. STREET ADDRESS (If rural, give location)				
					5906 MONTGOMERY STREET				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
MALE	WHITE	MARRIED	02-28-08	59					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
SUPVR.			B&O RAILROAD		PENNSYLVANIA		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
THOMAS DEC 'D					ANNA (DENSER)				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO					WILKENS & CATON AVES. ST. AGNES RECORDS-BALTO., MD. 21229				
18. <u>163X I</u> CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) <u>Bacterial Pneumonia</u>				
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)					DUE TO				
ANTECEDENT CAUSES					(B) <u>adenocarcinoma lung</u>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost.					DUE TO				
					(C) _____				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				YES		yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 15, 19 67 to JULY 2, 19 67, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 2, 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
<u>Carl Matthey</u>					7/2/1967				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
CARL MATTHEY,					WILKENS & CATON AVES. ST. AGNES HOSPITAL-BALTO., MD. 21229				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		24E. (State)	
Burial		7/6/1967		Calvary Cemetery		Pittsburgh, Pennsylvania			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUL 3 1967		<u>Robert E. Jenkins</u>		<u>Leamon Lemmon</u>		4611 Park Heights Ave.			

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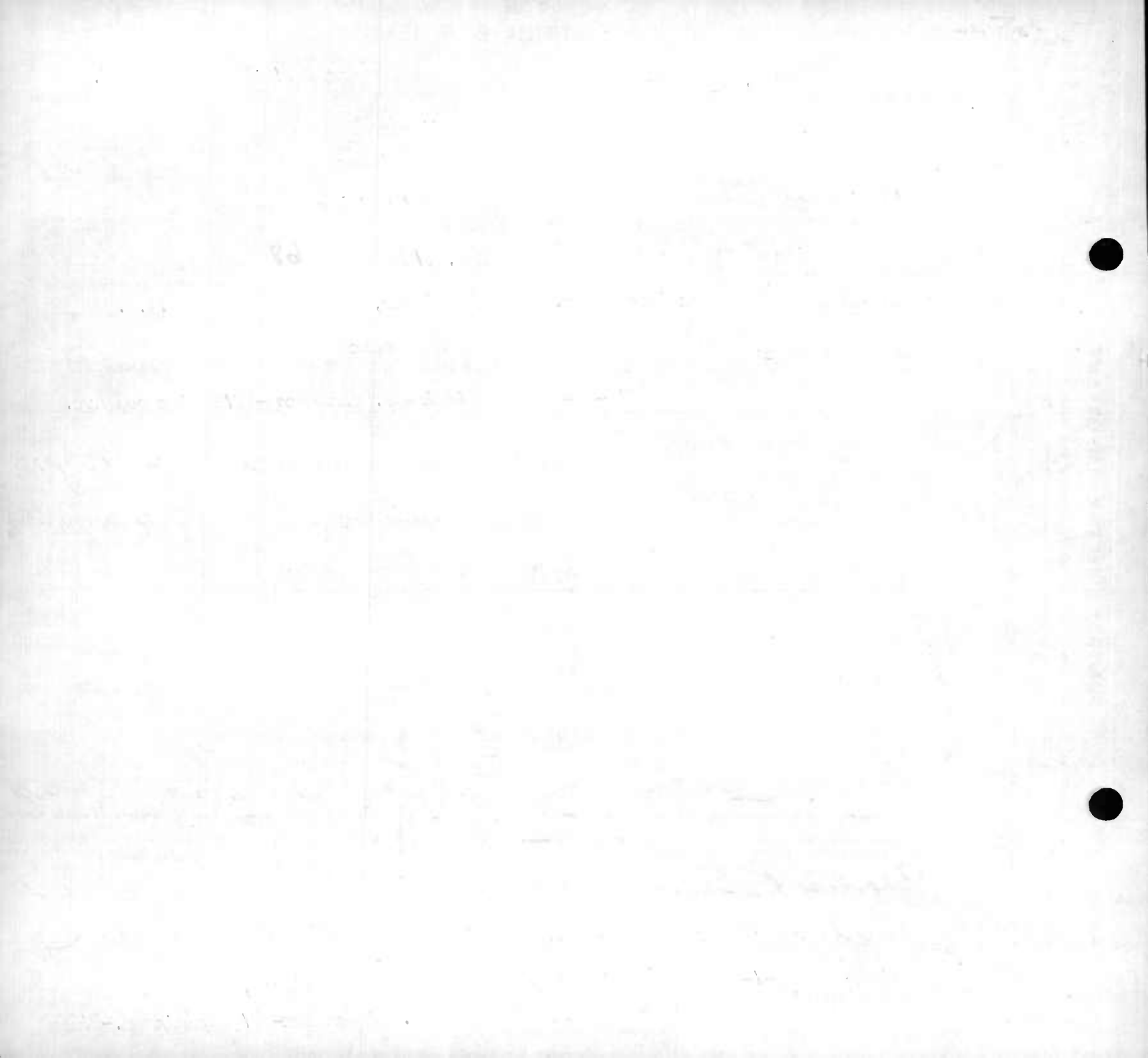
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6327		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6327	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Leo P. Barranco</i>		2. DATE AND HOUR OF DEATH <i>June 27, 1967</i> <i>8P.</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2412 Pinewood Avenue</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2412 Pinewood Avenue</i>		27-07	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>Mar. 6, 1899</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Nochiemontz Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
13. FATHER'S NAME <i>Joseph Barranco</i>		14. MOTHER'S MAIDEN NAME <i>Mary DeLuca</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-09-4939</i>		17. INFORMANT <i>Lillian A. Barranco</i> ADDRESS <i>4212 Pinewood Ave.</i>	
18. <i>199-21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Aspiration Pneumonia</i> DUE TO (B) <i>Carcinomatosis</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>4 months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2/7/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholelithiasis</i>		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/2</i> 19 <i>66</i> to <i>6/27</i> 19 <i>67</i> , that (I) <del>was</del> last saw the deceased alive on <i>6/26</i> 19 <i>67</i> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <i>Isadore K. Grossman</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>6/28/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Isadore K. Grossman</i>		23D. ADDRESS <i>1527 E. North Ave</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-1-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. DATE REC'D BY HEALTH DEPT. <i>JUL 3 1967</i>			
25A. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>John C. Miller Inc-6415 Belair Rd.-21206</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6328		67 6328		67 6328	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>HOPKINS, JOSEPH M.</b>			2. DATE AND HOUR OF DEATH <b>6/30/67 3:15-P M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>FRANKLIN SQUARE Hosp.</b>			A. STATE <b>MARYLAND</b> B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21-01</b>		
			D. STREET ADDRESS (If rural, give location) <b>814 HANBOLD ST. (21230)</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>Jul 16, 1908 59</b>	9. AGE (In years last birthday)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Rogers Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>GEORGE HOPKINS</b>		14. MOTHER'S MAIDEN NAME <b>ADA FISHER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-09-8632</b>		17. INFORMANT <b>BOB A. HOPKINS ST. (Sons)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>420.51</b>		CAUSE OF DEATH <b>ACUTE MYOCARDIAL INFARCTION VENTRICULAR FIBRILLATION</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/8 1967</b> to <b>6/30 1967</b> , that (I) (we) last saw the deceased alive on <b>6/30 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Francisco</b>				23B. DATE SIGNED <b>6/30/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. KATE S. M. CALIZO</b>				23D. ADDRESS <b>FRANKLIN SQUARE Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/3/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairburne</b>	
25C. FUNERAL DIRECTOR <b>John J. Cowan Inc.</b>		25D. ADDRESS <b>901 Hollins St - 21223</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

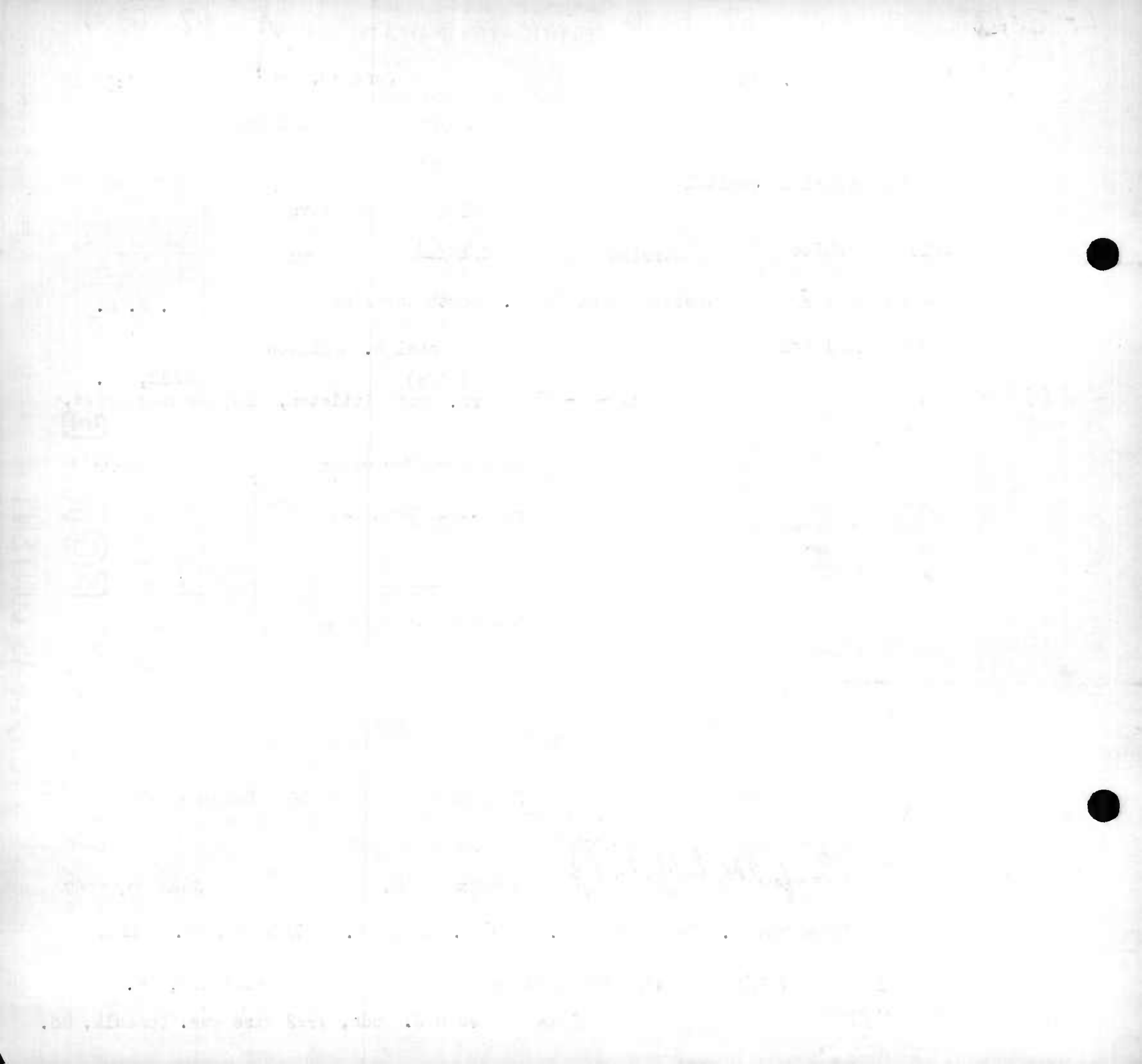
BIRTH NO. 67 6329		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6329	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Hester Lavine Dye</i>		
2. DATE AND HOUR OF DEATH <i>June 28, 1967 10 30 P. M.</i>			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		(If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
A. STATE <i>MARYLAND</i>		B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>	
D. STREET ADDRESS (If rural, give location) <i>2626 MATHEWS STREET</i>		E. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>9-04</i>		F. STREET ADDRESS (If rural, give location)	
5. SEX <i>FEMALE</i>	6. RACE <i>CAUCASIAN</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>02-29-88</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>George Mc Manus</i>		14. MOTHER'S MAIDEN NAME <i>NANCY STEVEN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>HARRISON DYE</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Cerebrovascular Accident</i>		<i>25 days</i>	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Pneumonia</i>		<i>10 days</i>	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>No</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>JUNE 13</i> 19 <i>67</i> to <i>JUNE 28</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>JUNE 28</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sam W. Boal</i>				23B. DATE SIGNED <i>6/28/67</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>7/1/67</i>	24C. NAME OF CEMETERY or CREMATORY <i>Bloomington</i>		24D. LOCATION (City, town, or county) (State) <i>Bloomington Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 3 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>E. J. Boal</i>	
				ADDRESS <i>Westernport, Md.</i>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6330	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 67 6330</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>1. NAME OF DECEASED</b> (Type or Print) <b>Ray C. Littleton</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>June 29, 1967</b>   <b>4:30 AM</b> M.		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>5. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>Dundalk</b> <b>6. STREET ADDRESS</b> (If rural, give location) <b>8204 Guntree Drive</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>2/18/06</b>	<b>9. AGE</b> (In years last birthday) <b>61</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Press Operator</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Western Electric Co.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>North Carolina</b>	
<b>13. FATHER'S NAME</b> <b>John Littleton</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Mabel S. Hamilton</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216-03-5938</b>		<b>17. INFORMANT</b> <b>(Wife)</b> <b>Dundalk, Md.</b> <b>Mrs. Myra Littleton, 8204 Guntree Drive,</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>5271 I</b> <b>Pulmonary Emphysema</b> (A) DUE TO <b>Pulmonary fibrosis</b> (B) DUE TO (C)			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 years</b>		
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> <b>Right heart failure</b>					
<b>19A. DATE OF OPERATION</b> <b>None</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>No</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <b>No</b>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>None</b>	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from July 30 19 65 to February 27 19 67, that (I) (we) last saw the deceased alive on February 27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>Crawford N. Kirkpatrick Jr.</i> M.D.				<b>23B. DATE SIGNED</b> <b>June 30, 1967</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Crawford N. Kirkpatrick Jr. M.D.</b>		<b>23D. ADDRESS</b> <b>6 E. Eager St. Baltimore, Md. 21202</b>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>7/3/67</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Oak Lawn Cemetery</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md.</b>					
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JUL 3 1967</b>		<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Fairburn</i>		<b>25C. FUNERAL DIRECTOR</b> ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 6331</span>	
BIRTH NO. <span style="float: right;">67 6331</span>				CERTIFICATE OF DEATH	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>SOUDER ESTHER B</b>				2. DATE AND HOUR OF DEATH <b>JUNE 26 1967 3:00A</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Howard</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>LAUREL</b> D. STREET ADDRESS (If rural, give location) <b>2ND AND MADISON STS BOX 56 RT 5</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>2-28-99</b>	9. AGE (In years lost birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>WESLEY SOUDER</b>		
14. MOTHER'S MAIDEN NAME <b>SUZANNA GITTINGS</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>218-24-0327</b>			17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVE</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASCUD with severe hypertension and CHF.</b>				INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>late onset diabetes</b>					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JUNE 15 1967</b> to <b>JUNE 26 1967</b> , that (I) (we) last saw the deceased alive on <b>JUNE 26 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John B. Herts</b>				23B. DATE SIGNED <b>6-26-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>John B. Herts</b>				23D. ADDRESS <b>CATON &amp; WILKENS AVE. BALTO MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/29/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Emanuel</b>	
24D. LOCATION (City, town, or county) (State) <b>Scaggsville Howard Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Donaldson Laurel, Md</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6332</b>	
BIRTH NO.		67 6332		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		<b>ANTHONY ZEMAITIS</b>		2. DATE AND HOUR OF DEATH <b>JUNE 30, 1967 11:35 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVENUE BALTIMORE 29, MARYLAND</b>		A. STATE <b>MARYLAND</b>		B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>728 BROOKWOOD ROAD</b>		<b>21229</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-17-95</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>PETE ZEMAITIS</b>		14. MOTHER'S MAIDEN NAME <b>ROSE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>215-10-2828</b>		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AV</b>	
18. <b>523.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Pulmonary emphysema</b> DUE TO (B) <b>Silicosis</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JUNE 28 1967</b> to <b>JUNE 30 1967</b> , that (I) (we) last saw the deceased alive on <b>JUNE 30 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. Braun</i>				23B. DATE SIGNED <b>6/30/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. A. BRAUN</b>				23D. ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/5/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>		25B. NAME OF REGISTRAR <i>Robert E. Farkas</i>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-462		67 6333		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6333	
BIRTH NO.		M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
MARY SALARIS		6/29/67 6:20 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY					
CHURCH HOME & HOSPITAL		305 S. NEWKIRK MD.					
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
		BALTO				26-07	
		D. STREET ADDRESS (If rural, give location)					
		305 S NEWKIRK					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	
F	W	MARRIED	7/5/91	76			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		—		Greece		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
PETRO PETRIDES				ARGIRO KABUKI			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		—		Mr. Costas Salaris		305 S. Newkirk St, Baltimore, Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
331X I		Cerebrovascular accident days.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO Pneumonia				days	
		(B) DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Generalized Arteriosclerosis				yes.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/28/67 to 6/29/67. that (I) (we) last saw the deceased alive on 6/29/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Francis Baltazar M.D.				6/29/67			
25C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
FRANCIS BALTAZAR M.D.				CHURCH HOME & HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/1/67		Greek Orthodox Com.		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 3 1967		Robert E. Farber		Nicholas T. Matthews		3021 Eastern Ave, Baltimore, Md.	

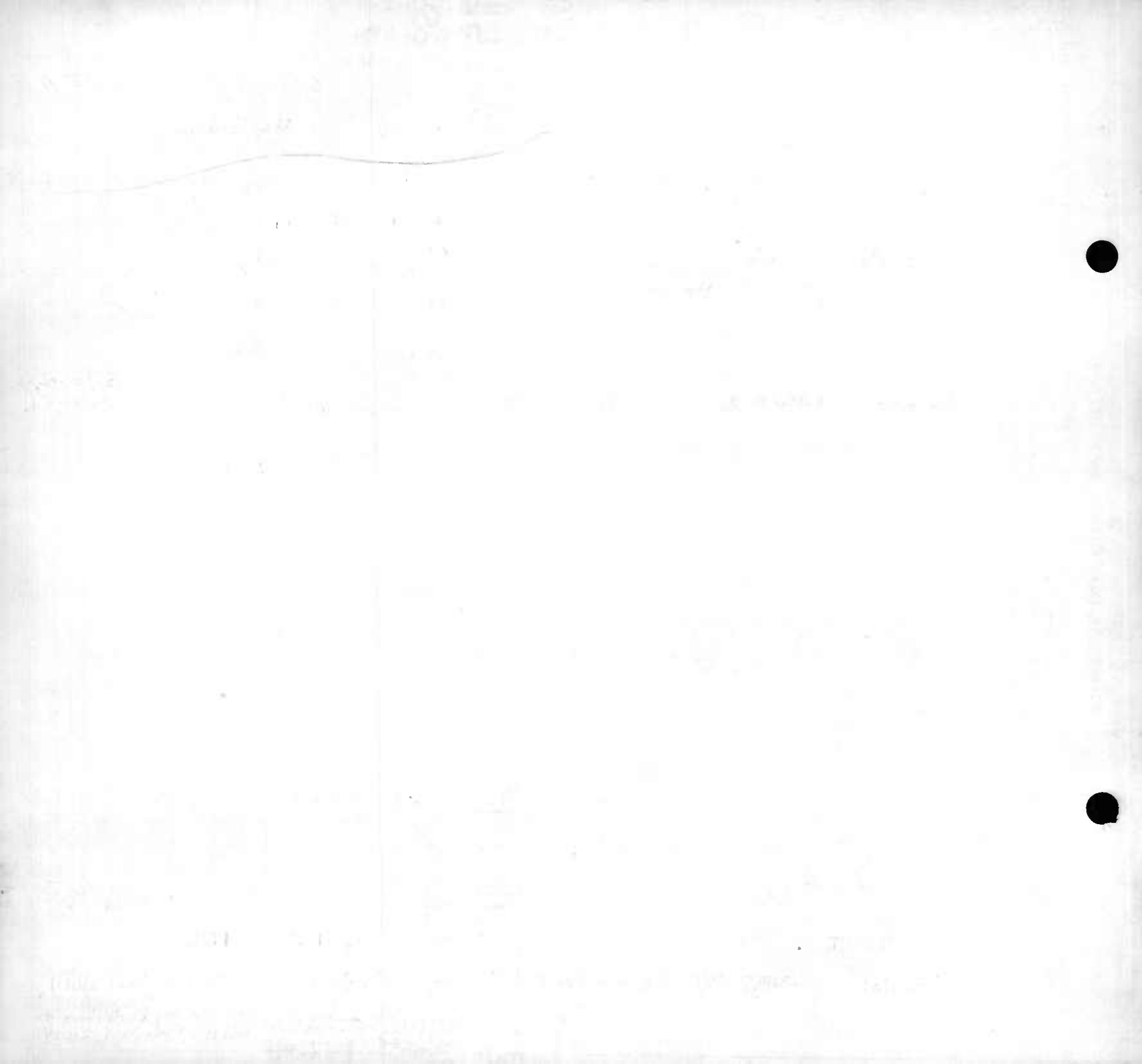




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 6334		67 6334		X	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Edna M. Fowler	
2. DATE AND HOUR OF DEATH		6/30/67 11 35 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
The Johns Hopkins Hospital		MARYLAND Harford Co.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
Female		White		Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Homemaker		North Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Coleman Moore		Caroline Clarke		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes <del>No</del>		WW # 2		244-38-7328	
18. 15-3-31		CAUSE OF DEATH		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		314 Ewing St. Bel Air, Md.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/25 1967 to 6/30 1967, that (I) (we) last saw the deceased alive on 6/29/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Robert W. Swan				6/30/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ROBERT W. SWAN		THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		July 3, 1967		Bel Air Memorial Gardens	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 3 1967		Robert E. Fawcett		Joseph William Foster	
				ADDRESS	
				W. Broadway & Williams St. Bel Air, Maryland 21014	



D-623

67 6335

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 67 6335

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Irene M. Dorst

2. DATE AND HOUR OF DEATH

6/30/67

12<sup>30</sup> AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1315 Gregor Way 21224 007

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

11-6-91

9. AGE (In years lost birthday)

75

(If Under 1 Yr. Months Days Hours Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George Bein

14. MOTHER'S MAIDEN NAME

Barbara Kreuzer

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

220125015A

17. INFORMANT

BCH: Records 4940 Eastern Ave. Baltimore, Md.

ADDRESS

# 21224

18. 340.3 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

GI Bleeding (stress ulcer)

INTERVAL BETWEEN ONSET AND DEATH

10 days

(B) DUE TO

Meningitis

23 days

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Renal tubular necrosis

1 day

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/7 1967 to 6/30 1967, that (I) (we) last saw the deceased alive on 6/29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Wm A. Emerson

M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

6/30/67

23C. PHYSICIAN'S NAME (Type)

Wm. A. Emerson

M.D.

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Ave. Baltimore, Maryland #21224

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/3/67

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 3 1967

25B. NAME OF REGISTRAR

Robert E. Farber

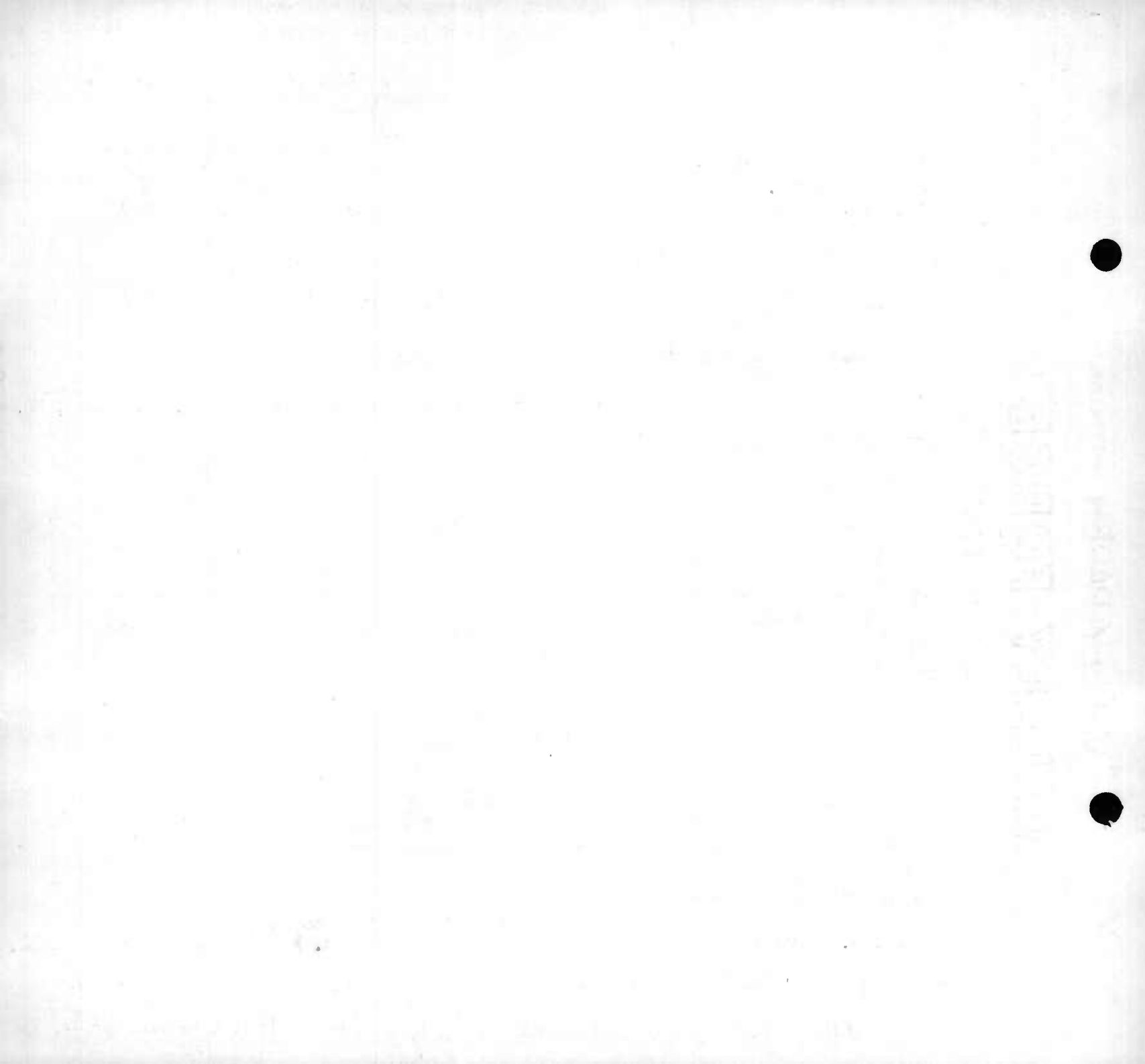
25C. FUNERAL DIRECTOR

Phyllis E. Cook 1211 Chesebrough Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

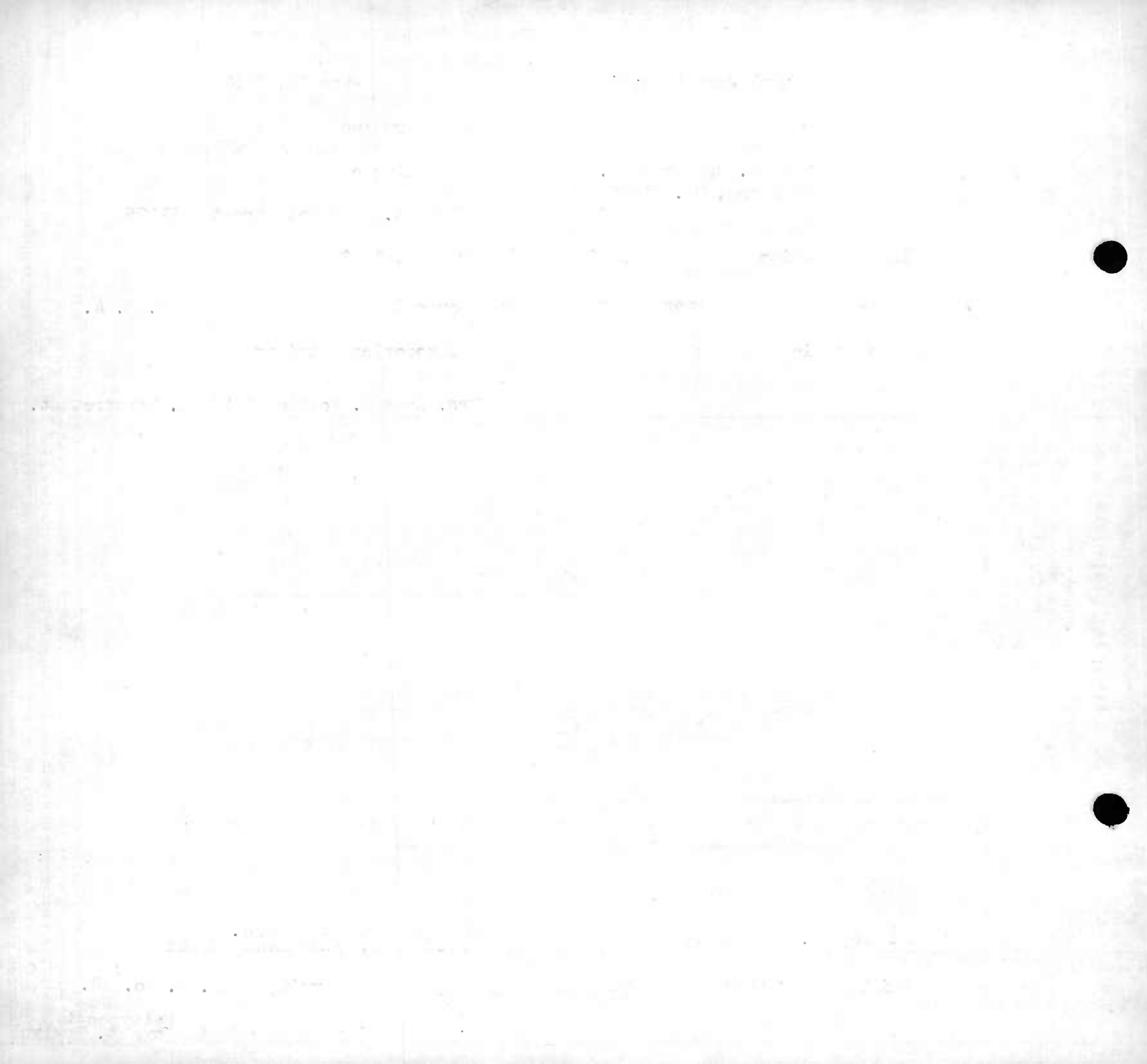
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6336		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6336	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				Aurel Joseph Kostin			
2. DATE AND HOUR OF DEATH				June 30, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
3725 St. Margaret St.		Baltimore, Md. 21225		Maryland			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
Baltimore				3725 St. Margaret Street 21225			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		White		Married		March 22, 1903	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)	
Foreman		Amer Sugar Refinery		Roumonia		64	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
U. S. A.				George Kostin			
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
Theodorica Petrican				16. SOCIAL SECURITY NO.			
17. INFORMANT				ADDRESS			
Mrs. Anna M. Kostin				3725 St. Margaret St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Cerebrovascular disease		6 years	
ANTECEDENT CAUSES		(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from		10/10		1961 to		6/30 1967.	
that (I) (we) last saw the deceased alive on		6/13		1967		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Sidney R. Gehlert,						6/30/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
Sidney R. Gehlert,		4700 Pennington Ave. Baltimore, Maryland 21226					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/3/67		Holy Cross Cemetery		Brooklyn A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 3 1967		Robert E. Farber		McCully Funeral Home		Patapsco & 3rd St. Brklyn	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

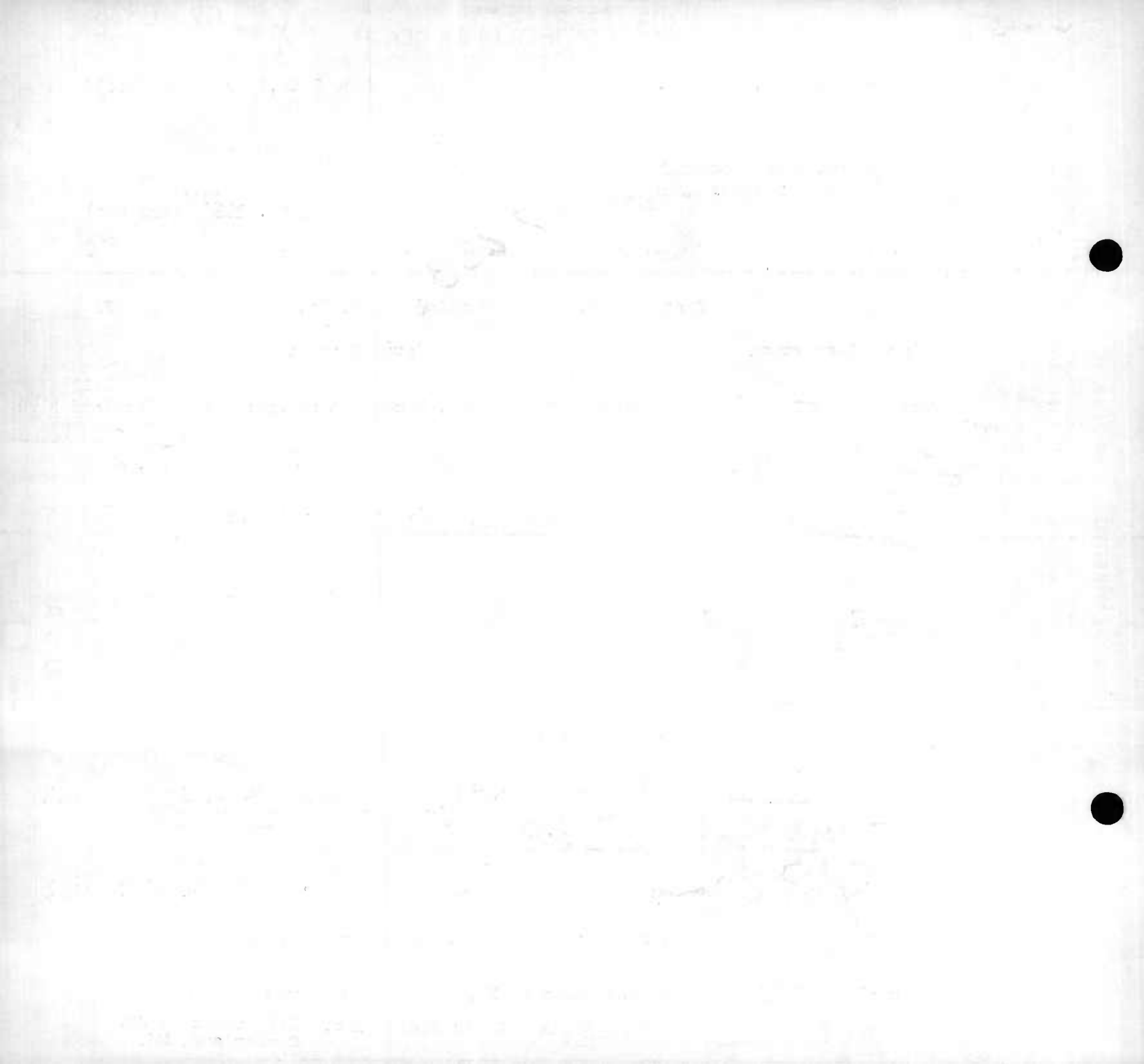
BIRTH NO. 67 6337				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6337	
1. NAME OF DECEASED (Type or Print) <b>Francis Howard Matherly</b>				2. DATE AND HOUR OF DEATH <b>June 30, 1967 10:05 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital 3100 Wyman Pk. Drive</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>W. Va.</b> B. COUNTY <b>V-45</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Statebury Sophia</b> D. STREET ADDRESS (If rural, give location) <b>Box 33</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7/27/22</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Coal Miner</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Forest Matherly</b>				14. MOTHER'S MAIDEN NAME <b>Verda Cook</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes USN 1943-1946</b>		16. SOCIAL SECURITY NO. <b>235-18-3326</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Lobar pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute myelogenous leukemia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Terminal</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 12 1966</b> to <b>June 30 1967</b> , that (I) (we) last saw the deceased alive on <b>June 30 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Michael E. Pelczar</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <b>6/30/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Michael E. Pelczar, SA Surgeon (R)</b> M.D.		23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24B. DATE <b>7/1/67</b>		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>Williams F.H. Sophia, W. Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Inc. 1217 St. Paul St.</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 6338		Registered No. 67 6338	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Leatherman, Harry E.		June 27th, 1967 11:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Saint Agnes Hospital		Caton & Wilkens Aves 21229		Maryland		Baltimore	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				4749 Westland Blvd. 21227 (Arbutus)			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	(If Under 1 Yr. Months Days Hours Min.)		
Male	White	Married	2/15/97	70			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired		State of Md.		Burlington, W. Va.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jacob Leatherman				Sarah Feaster			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		WWI		235-30-0304		Mrs. Dorothy Leatherman 4749 Westland Blvd 21227	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) CORONARY OCCLUSION			
ANTECEDENT CAUSES				(B) Atherosclerotic CV Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				1 HR.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 28 1962 to June 27 1967, that (I) (we) lost saw the deceased alive on June 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
John Schaefer						June 28 1968	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
John Schaefer		401 Random Rd., Balto., Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/1/67		Sunset Memorial Pk.		Cumberland, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 3 1967		Robert E. Farber		Louis Stein, Inc.		117 Frederick St. Cumberland, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6339				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6339	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) <del>ELIZABETH</del> MABEL SPAHN				E.		6/28/67 1:05 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
ST. AGNES HOSPITAL				MARYLAND			
5. SEX FEMALE				6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	
8. DATE OF BIRTH 3-7-08				9. AGE (In years lost birthday) 59		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HENRY MILLER				14. MOTHER'S MAIDEN NAME JENNIE WISEMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGNES RECORDS WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO Carcinoma, pancreas & breast tract			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 06/05/67 19 to 06/28 1967, that (XX) (we) last saw the deceased alive on 06/28/67 19 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-28-67	
23C. PHYSICIAN'S NAME (Type) XXXXXX XXXXXX ROLANDO DEL ROSARIO				23D. ADDRESS M.D. ST. AGNES HOSPITAL-WILKENS & CATON AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-1967		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

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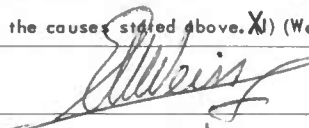
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6340				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6340	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARINO, DOMINICK J.</b>				2. DATE AND HOUR OF DEATH <b>JUNE 29, 1967</b>		<b>6:40 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b> <b>CATON AND WILKENS AVENUES</b> <b>BALTIMORE, MD. 21229</b>				A. STATE B. COUNTY <b>MARYLAND 21227</b>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>2505 W. PATAPSCO AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>12/24/07</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SPLICER-RIGGER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MD. DRYDO CK</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SAMUEL SALVATORE MARINO</b>				14. MOTHER'S MAIDEN NAME <b>SADIE BATTAGLIA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>				16. SOCIAL SECURITY NO. <b>217 05 5183</b>		17. INFORMANT ADDRESS <b>HOSPITAL RECORDS-ST. AGNES HOSPITAL</b>	
18. <b>72011</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYO. INFARCTION</b> <b>ESSENTIAL HYPERTENSION</b> <b>AS CVD</b>				INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 29, 19 67</b> to <b>JUNE 29, 19 67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JUNE 29, 19 67</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED <b>6-30-67</b>			
23C. PHYSICIAN'S NAME (Type) <b>E.H. Weiss</b>				23D. ADDRESS <b>ST. AGNES HOSPITAL-CATON &amp; WILKENS AVES BALTO. MD. 21229</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/3/67</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, MA</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. 21229</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6341	
BIRTH NO. 67 6341		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>MACZKA VINCENT</b>		VINCENT MACZKA		2. DATE AND HOUR OF DEATH <b>7/2/67</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinai Hospital</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>Baltimore</b>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>23 1/2 Eastern Ave Bldg</b>			
5. SEX <b>m</b>	6. RACE <b>w</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>March 25, 1908</b>	9. AGE (in years last birthday) <b>59</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Used Car Lot</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO, Md.</b>	
13. FATHER'S NAME <b>Walenty Maczka</b>		14. MOTHER'S MAIDEN NAME <b>Alice Gietka</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Daisy Maczka 23 1/2 Eastern Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>163X I</b>		CAUSE OF DEATH (A) DUE TO <b>Pelmonary Embolism</b> (B) DUE TO <b>Se cell CB of right lung 4 days</b> (C) <b>Post op pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>7-6-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Se cell CB</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-2-67</b> to <b>7-2-67</b> that (I) (we) last saw the deceased alive on <b>7-2-67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>T. J. Conception</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>7-2-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Tomas J. Conception</b>		23D. ADDRESS <b>% Sinai Hosp. of Baltimore</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-6-1967</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Stanislaus</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6342		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6342	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) FRANK A. STEFANSKI			2. DATE AND HOUR OF DEATH July 1, 1967		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5100 Eastbourne Avenue		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Sept. 27, 1907	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Box Maker		10B. KIND OF BUSINESS OR INDUSTRY American Radiator		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME John Stefanski			14. MOTHER'S MAIDEN NAME Mary Kujawa		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service WW II 11-12-42 11-1-45			16. SOCIAL SECURITY NO. 213-01-4357		
			17. INFORMANT Miss Antoinette Deca 1002 S. Clinton St.		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Myocardial cardiac infarction</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 1 min.
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1 Jul 67 19 to 1 Jul 67 19 that (I) (we) last saw the deceased alive on 1 Jul 67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jos. B. Bronushas</i>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3 Jul 67
23C. PHYSICIAN'S NAME (Type) JOS. B. BRONUSHAS			23D. ADDRESS 3037 6th DONNEIL ST BALTO. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-1967		24C. NAME of CEMETERY or CREMATORY St. Stanislaus	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.	

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BIRTH NO. 67 6343 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6343

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILBUR C. KRITWISE

2. DATE AND HOUR PRONOUNCED DEAD

June 28, 1967

12:25 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

518 Stamford Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 518 Stamford Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Oct. 6/06

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Sec.-Treas.

10B. KIND OF BUSINESS OR INDUSTRY

Falconer Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frederick Kritwise

14. MOTHER'S MAIDEN NAME

Laura Cain

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Helen Rumney

ADDRESS

518 Stamford Rd. - 21229

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 28, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7/1/67

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 3 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Witzke F. D. - 4101 Edmondson Av.

ADDRESS

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BALTIMORE CITY HEALTH DEPARTMENT

67 6344

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM STRAWSER

2. DATE AND HOUR PRONOUNCED DEAD

June 28, 1967

2:00 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

113 S. Calhoun Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 5, 1903

9. AGE (In years  
lost birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

W. Va.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
217-10-659817. INFORMANT  
Mrs. Wm. B. Strwser  
113 S. Calhoun St.

ADDRESS

18. 420.0 I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic heart disease

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

6/30/67

23C. NAME OF CEMETERY or CREMATORY

Loudon Park Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 3 1967

Robert E. Finkbeiner

Witzke F. D. - 4101 Edmondson Ave.

June 1, 1947

Warren

W. J.

Mr. W. J. Springer  
113 E. Calhoun St.

113-10-1530

Billings, MT.

London, Ont.

WJW

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6345					Registered No. 67 6345				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Hedwig Sonia Schuster					June 29, 1967 6: 40 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
US Public Health Service Hospital 3100 Wyman Park Drive					W. Va.				
5. SEX					6. RACE				
F					W				
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)					8. DATE OF BIRTH				
Div.					3/4/11				
9. AGE (In years last birthday)					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				
56					Housewife				
11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
Germany					? Germany				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Wilhelm Kimmetz					Elsa Summers				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
No					?				
17. INFORMANT					ADDRESS				
Records- US PHS Hospital,					Balto, Md.				
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH									
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)									
Reticulum cell carcinoma									
(A) DUE TO									
INTERVAL BETWEEN ONSET AND DEATH									
Months									
ANTECEDENT CAUSES									
(B) DUE TO									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
(C) DUE TO									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION									
2									
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20A. AUTOPSY? (Yes or No)									
yes									
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
yes									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)									
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)									
21E. INJURY OCCURRED									
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from June 12 19 67 to June 29 19 67, that (I) (we) last saw the deceased alive on June 29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE									
Michael E. Pelczar M.D.									
23B. DATE SIGNED									
6/30/67									
23C. PHYSICIAN'S NAME (Type)									
Michael E. Pelczar, SA Surg (R) M.D.									
23D. ADDRESS									
US PHS Hospital, Balto, Md.									
24A. BURIAL CREMATION, REMOVAL (Specify)									
burial									
24B. DATE									
7/2/67									
24C. NAME OF CEMETERY or CREMATORY									
Elmwood Cemetery									
24D. LOCATION (City, town, or county) (State)									
Shepherdstown, W. Va.									
25A. DATE REC'D BY HEALTH DEPT.									
JUL 3 1967									
25B. NAME OF REGISTRAR									
Robert E. Jackson									
25C. FUNERAL DIRECTOR									
Melvin T. Strider Co., Charles Town, W. Va.									





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6346					Registered No. 67 6346				
CERTIFICATE OF DEATH									
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
				SAUER Helen E.			6-30-67 4:25 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins					A. STATE MARYLAND				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21212				
					D. STREET ADDRESS (If rural, give location) 5502 LEITH RD.				
5. SEX F.	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 12-12-99	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partner, Container Business				10B. KIND OF BUSINESS OR INDUSTRY Business		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK A. Sauer					14. MOTHER'S MAIDEN NAME CATHERINE MULLER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217 20 5965		17. INFORMANT Mrs. Margaret E. Bauer (sister) 5502 Leith Rd. Baltimore Md. 21212			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) DUE TO METASTATIC BREAST CARCINOMA (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 18 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DEHYDRATION					3 weeks				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 5-28-67 to 6-30-67, that (I) (we) last saw the deceased alive on 6-30-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE JAMES L. PHILLIPS M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-30-67		
23C. PHYSICIAN'S NAME (Type) James L. Phillips M.D.					23D. ADDRESS Johns Hopkins Hospital				
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE July 5, 1967		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1967		25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. Baltimore Md.			ADDRESS	

25-03-58

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STATISTICAL BUREAU  
CHICAGO

DEHYDRATION  
NO.

James H. Miller

X

6-30 P.M. 10

6-30 P.M.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6347</b>	
BIRTH NO. <b>67 6347</b>			<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.			2. DATE AND HOUR OF DEATH <b>July 2, 1967</b>		
1. NAME OF DECEASED (Type or Print) <b>Rida M. Pomp</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Belvedere House in the Pines</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4810 Gwynn Oak Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>1-1-1871</b>	9. AGE (In years lost birthday) <b>96</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Pomp</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ann Wattlington</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-46-1690T</b>	17. INFORMANT <b>Mrs. Arthur Opfer-4602 Simms Ave. # 6</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. If means the disease, injury or complication which caused death.) <b>CEREBRAL ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 YRS.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>FALL 1955</b> to <b>JULY 2, 1967</b> that (I) (we) last saw the deceased alive on <b>JUNE 27, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <b>Marvin Goldstein</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>3 JULY 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARVIN GOLDSTEIN</b> M.D.				23D. ADDRESS <b>6001 PARK HEIGHTS AVE. BALTO. MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-5-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>4600 Liberty Hgts Avenue Baltimore, Maryland 21207</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6348				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6348	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Evelyn Canna Coward				2. DATE AND HOUR OF DEATH 6/29/67 1 8 <sup>15</sup> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital				A. STATE B. COUNTY MARYLAND Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Ruxton 03-00			
				D. STREET ADDRESS (If rural, give location) 1401 Boyce Ave			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 11/28/08	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph S. Underwood				14. MOTHER'S MAIDEN NAME Gertrude Lovett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Capt. George W. Coward Jr. 1401 Boyce Ave.	
18. 204.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Chronic Lymphocytic Leukemia				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 7 YRS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natally medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 6/17 to 6/29 1967, that (1) (we) last saw the deceased alive on 6/29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sandra Z. Salan M.D.				23B. DATE SIGNED 6/29/67		23C. PHYSICIAN'S NAME (Type) Sandra Z. Salan M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-67		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Memorial		24D. LOCATION (City, town, or county) (State) Cockeysville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1967		25B. NAME OF REGISTRAR Robert E. Fabela		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.		25D. ADDRESS 1050 York Rd.	



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M-520

67 6349

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6349

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ISAAC E. MONK

2. DATE AND HOUR PRONOUNCED DEAD

July 1, 1967

11:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1030 N. Patterson Park Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1030 N. Patterson Park Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

2-23-1914

9. AGE (In years  
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Shipyard

11. BIRTHPLACE (State or foreign country)

Dunn, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jack Monk

14. MOTHER'S MAIDEN NAME

Sarah Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

218-10-4697

17. INFORMANT

Janie Monk 1030 N. Patterson St.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinoma of esophagus  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 1, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-5-67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery Anne Arundel Co., Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 3 1967

24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

Randolph J. Collick 2431 E. Oliver St.

ADDRESS





1  
S-410

BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No. 67 6350			
BIRTH NO. 67 6350				M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <b>ROBERT SELBY or Robert Silby</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>June 28, 1967 1:25 a.m.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>9-09</b>							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1404 N. Central Avenue</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>							
				D. STREET ADDRESS (If rural, give location) <b>1404 N. Central Avenue</b>							
5. SEX <b>Male</b>		6. RACE <b>Colored</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>9-19-1926</b>		9. AGE (In years last birthday) <b>40</b>		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <b>Eva Flowers</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>225-20-1707</b>				17. INFORMANT <b>Mrs. Ollie Mae Silby, 1404 N. Central Ave.</b>			
18. <b>422.1</b>				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular</b>				(A) DUE TO							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Heart Disease</b>				(B) DUE TO							
				(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Fatty infiltration of liver</b>											
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED			
ACTUAL SIGNATURE <b>Russell S. Fisher</b> EXAMINER'S NAME (Type) <b>Russell S. Fisher</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>7-1-67</b>		23C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Md.</b>					
24A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		24C. FUNERAL DIRECTOR <b>Randolph J. Collick</b>		ADDRESS <b>2431 E. Oliver St.</b>					

R-14

at Robert Zilly

2-0-2  
2-0-2

Robert

Construction

married

4-14-1936

Virginia

N.2.A.

Evans Flowers

no

336-20-1207 Mr. Office 2114 North 1st Ave.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6351		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 6351			
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH							
(Type or Print)		Drew, HELEN		6/20/67		2 <sup>00</sup>		A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE							
The Johns Hopkins Hospital				Maryland							
601 North Broadway				C. CITY OR TOWN (If outside city limits, write RURAL and give township)							
Baltimore, Maryland				Baltimore							
				D. STREET ADDRESS (If rural, give location)							
				1420 Argyle Avenue							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months		If Under 24 Hrs. Days				
Female	Negro	Married	8/17/20	46 yrs.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Domestic						Smithfield, Virginia		U.S.A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
Butler, William L.			Clark, Daisy								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS			
			228-36-8430			Mr. Percell Drew		1420 Argyle Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			A. DUE TO			Carcinoma of Breast 3 yrs					
ANTECEDENT CAUSES			B. DUE TO								
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			C. DUE TO								
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2				YES		NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (1) (this hospital) attended the deceased from			19 6/27			to 6/30			19 67		
that (1) (we) last saw the deceased alive on			6/29			19 67			and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		
23A. SIGNATURE			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED					
Sherrard L. Hayes						6/30/67					
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS								
Sherrard L. Hayes			Johns Hopkins Hospital-601 N. Broadway								
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION		(City, town, or county)		(State)	
Burial		7-6-67		Smithfield Cemetery		Smithfield,				Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
JUL 3 1967		Robert E. Taylor		Morton E. Dyett FHL		1701 Laurens					



5-514

67 6352

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6352

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM

SAMPLE

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1967

2:48 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

847½ Boyd Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9-14-1920

9. AGE (In years  
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Longshore Man

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Craddockville, Va

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Mc Kinky Sample

14. MOTHER'S MAIDEN NAME

Ellie Sample

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

230-18-0305

17. INFORMANT

Mrs. Martha Johnson

ADDRESS

4419 Old York Rd.

18.

7-91X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Bronchopneumonia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST,

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fatty Alteration of Liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/30/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-5-67

23C. NAME OF CEMETERY or CREMATORY

Balt. National Cem.

23D. LOCATION

Balt.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 3 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Mortimer Dych FH.

ADDRESS

1701 Laurens St.

WILLIAM PAPER

WILLIAM PAPER

WILLIAM PAPER

WILLIAM PAPER

WILLIAM PAPER

WILLIAM PAPER

H-200

67 6353

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6353

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HERBERT

HICKS

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1967

11:05

P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1810 W. Lexington St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

2-5-1939

9. AGE (In years  
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard Jackson

14. MOTHER'S MAIDEN NAME

Annie Hicks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-34-9883

17. INFORMANT

Mrs. Mary Lucas

ADDRESS

1810 W. Lexington St.

18.

E 874.19

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Intravenous narcotism

(A).....  
DUE TO(B).....  
DUE TO

(C).....

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

II  
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Unknown

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

Unknown

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
6-30-67 ?

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Injected overdose of narcotics

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-1-67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-6-67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

A.A. Co.

(City, town, or county)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 3 1967

24B. NAME OF REGISTRAR

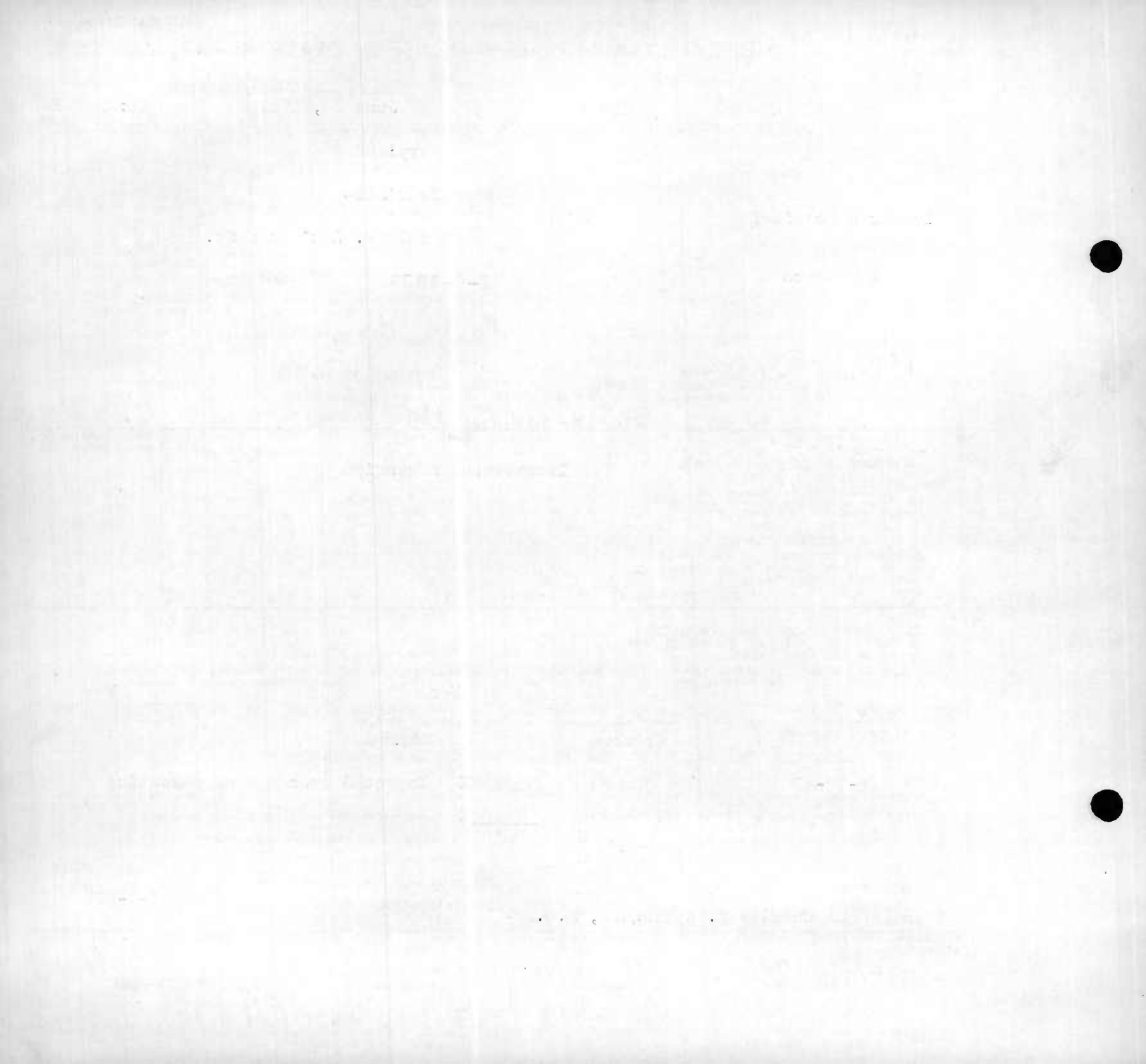
Robert E. Fabelo, M.D.

24C. FUNERAL DIRECTOR

Mortone Dyett F.H.

ADDRESS

1701 Laurens





w-452

67 6354

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 6354

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DONALD WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1967

10:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

841 Hillman Court

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

6-25-1925

9. AGE (In years  
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Handyman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY WILLIAMS

14. MOTHER'S MAIDEN NAME

MARIE JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

216-14-4530

17. INFORMANT

ADDRESS

Mrs. Mable Williams 841 Hillman Ct.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Epilepsy  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 30, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-3-67n

23C. NAME of CEMETERY or CREMATORY

BALTIMORE NAT'L CEM.

23D. LOCATION

(City, town, or county)

BALTIMORE,

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 3 1967

Robert E. Farber, M.D.

MORTON &amp; DYETT F.H. 1701 Laurens St.

QUALITY PAPER

300 SERIES CONTENT



1  
S-63067 6355  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6355

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FREDDIE SHORT

2. DATE AND HOUR PRONOUNCED DEAD

July 2, 1967

12:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2719 West Lafayette Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

1-1-1929

9. AGE (In years  
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BRUNSWICK COUNTY, VA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

W. H. Short

14. MOTHER'S MAIDEN NAME

Minnie Calber

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Beatrice Short 1927 W. Mulling St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Multiple traumatic injuries

(A).....  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B).....  
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Lafayette St. east of Ashburton St.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
7-1-67 11:15 P.

21E. INJURY OCCURRED

h.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 2, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-6-67

23C. NAME OF CEMETERY or CREMATORY

Little Zion

23D. LOCATION

(City, town, or county)

ALBERTA, VA.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 3 1967

Robert E. Farley, M.D.

MORTON + O'NEILL

1701 LAURENS ST

VALLEY 10000

VALLEY 10000

2

X

VALLEY 10000

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VALLEY 10000

67 6356

BALTIMORE CITY HEALTH DEPARTMENT

67 6356

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN E. WILSON

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1967

12:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

712 East Chase Street

Maryland General Hospital

(DOA)

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

10-19-1938

9. AGE (In years  
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

WYNNWOOD TOWERS

11. BIRTHPLACE (State or foreign country)

DANVILLE, VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN WILSON

14. MOTHER'S MAIDEN NAME

STELLA FARMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Nylon Gunn

712 E. Chase St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)Dislocation of upper cervical  
spine with transection of spinal  
cord

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(A) ~~XXXX~~

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?Jones Falls Expressway  
163 ft. south of 3 point marker21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
6-28-67 11:50 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-2-67

23C. NAME of CEMETERY or CREMATORY

WILSON CEMETERY

23D. LOCATION

DANVILLE,

(City, town, or county)

VIRGINIA

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MORTON &amp; DYETT F.H.

1701 Laurens S

JUL 3 1967

Robert E. Taylor, M.D.

UNITED STATES  
NATIONAL ARCHIVES  
COLLECTION

100-100000-100000

UNITED STATES  
NATIONAL ARCHIVES

T-635

BALTIMORE CITY HEALTH DEPARTMENT

67 6357

## CERTIFICATE OF DEATH

Registered No. 67 6357

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

STEPHEN TRATTNER

2. DATE AND HOUR OF DEATH

7-2-67 7:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Md. Baltimore 26-44  
3523 E. FAIRMOUNT Ave.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

M

8. DATE OF BIRTH

3-14-18

9. AGE (In years  
lost birthday)

79

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Sheet Metal

10B. KIND OF BUSINESS OR INDUSTRY

M. & Drydock  
Mk. Shipbuilding

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

PAUL TRATTNER

14. MOTHER'S MAIDEN NAME

CHRISTINA KRAUSE

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.

213-10-6112

17. INFORMANT

Mrs. Rita G. Trattner 3523 E. Fairmount

ADDRESS

AV

ount

18. 4-20-11

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) Acute Myocardial  
DUE TO INFARCT(B)  
DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

UNK.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-22-1967 to 7-2-1967,  
that (I) (we) last saw the deceased alive on 7-2-1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Eldon Hawbakker

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

7-2-67

23C. PHYSICIAN'S  
NAME (Type)

ELDON HAWBAKER

M.D.

23D. ADDRESS

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

7/6/67

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 3 1967

25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

25C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Baltimore

ADDRESS

St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

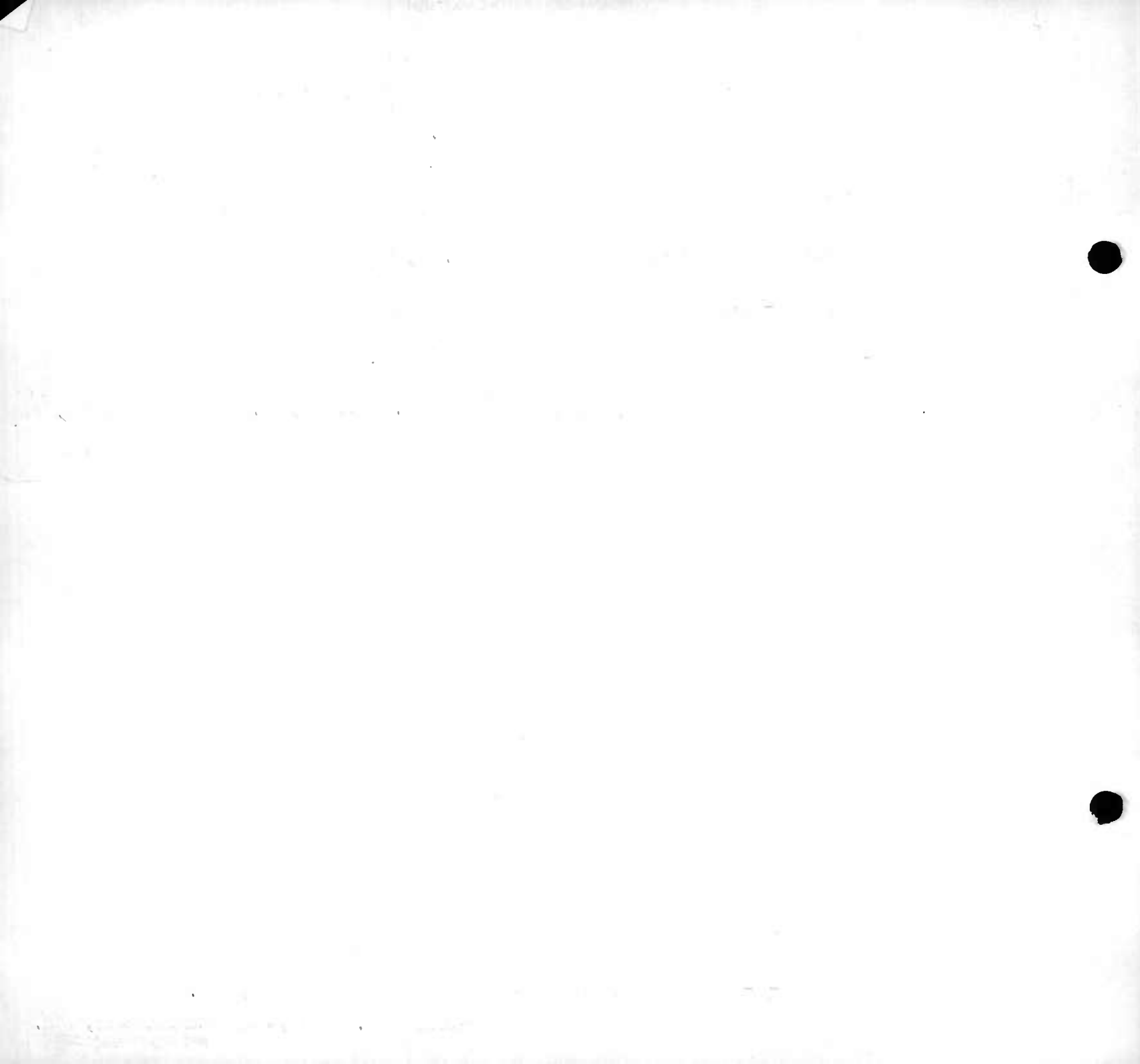
EDSON HAWBAKER



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 6358		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6358	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Louisa Sprigg		July 1, 1967 5:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)		Md.			
2448 Loch Raven Road		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 9-08	
		D. STREET ADDRESS (If rural, give location)		2448 Loch Raven Road	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
female	white	widowed	Sept. 16, 1892	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Proprietress - Confectionery Store				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Rapp		Louisa Diehle		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		217329773		Henry W. Sprigg, Jr. 5923 Chinguapin Pkwy	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Pulmonary Embolus			
ANTECEDENT CAUSES		(B) Due to Vascular Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Arterio Sclerotic C.V. Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 1967 to July 1, 1967, that (I) (we) last saw the deceased alive on June 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
M. Paul Byerly				July 3rd 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
M. Paul Byerly		5820 York Rd Baltimore 21212 MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
burial		7-5-67		Oak Lawn Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 3 1967		Robert E. Taylor, MA		Leonard J. Ruck, Inc Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6359	
BIRTH NO. 67 6359		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Raffaele Fazio		2. DATE AND HOUR OF DEATH June 30, 1967 9:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Park Drive		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 511 Park Avenue	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Div.	8. DATE OF BIRTH 7/7/01	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY USA		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Fazio		14. MOTHER'S MAIDEN NAME Mary Fantano	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes USA- WW 2		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 42011 Myocardial Infarction ASCVD		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 21 19 67 to June 30 19 67, that (I) (we) last saw the deceased alive on June 30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William L. Wilkie M.D.		23B. DATE SIGNED 7/1/67		23C. PHYSICIAN'S NAME (Type) William L. Wilkie M.D.	
23D. ADDRESS US PHS Hospital, Balto, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 3, 1967	
24C. NAME OF CEMETERY or CREMATORY Highlawn Memorial Park		24D. LOCATION (City, town, or county) (State) Oak Hill, West Virginia		25A. DATE RECEIVED BY HEALTH DEPT. JUL 3 1967	
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Wm. Cook-Brooks		25D. ADDRESS 1217 St. Paul St., Baltimore, Md.	

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William H. Miller

William H. Miller

William H. Miller

William H. Miller

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BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
67 6360				67 6360				67 6360			
M.E. CASE NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
				Maggie M Barton				July 2nd, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)							
Ashburton Nursing Home				Maryland							
5. SEX				6. RACE				7. MARRIED, NEVER MARRIED			
Female				White				WIDOWED, DIVORCED (specify)			
								Married			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
House-Wife								Shenandoah Va.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
Burton Petty				Mollie Hagley				USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				1				Marshall Barton 2127 Hollins St Balto. Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) Atherosclerosis							
ANTECEDENT CAUSES				(B) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO							
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
								20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Charles A Cahn				7/2.67							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
CHARLES A CAHN				2145 W Balto St Balto Md							
24A. BURIAL CREMATION REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
Removal				7/2/67				Kyger FH Shenandoah Va.			
25A. DATE RECEIVED BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
JUL 3 1967				Philip E. Tarkenton				Wm. Cook-Brooks, Inc. 1217 St Paul St			

Letter from Physician

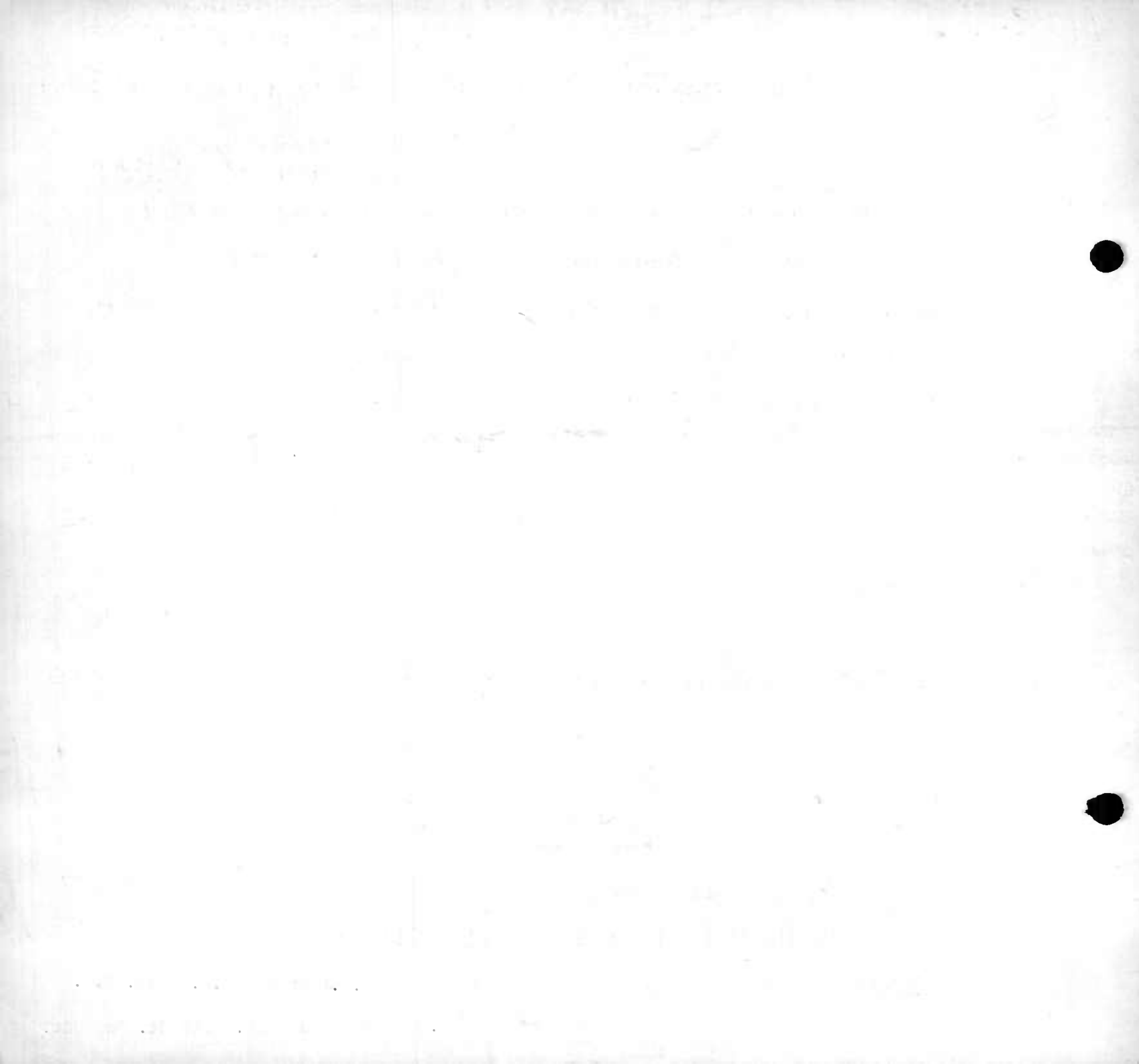
7-12-67

M.H.

# FUNERAL DIRECTOR: IMPORTANT

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M-235 67 6361		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 67 6361	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>WILLIAM BENTON McAdams</b>		2. DATE AND HOUR OF DEATH <b>July 1, 1967 6:30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hosp. WYMAN PARK DRIVE, Baltimore MD</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Montgomery</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>SILVER SPRING 65-10</b> D. STREET ADDRESS (If rural, give location) <b>12706 Chilton Circle</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-10-19</b>	9. AGE (In years lost birthday) <b>47</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SERVICE MAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AIR FORCE</b>		11. BIRTHPLACE (State or foreign country) <b>Ind.</b>	
13. FATHER'S NAME <b>ARTHUR McAdams</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
14. MOTHER'S MAIDEN NAME <b>Mabel Allen</b>			17. INFORMANT ADDRESS <b>Records - USPHS Hospital</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1942-1945</b>		16. SOCIAL SECURITY NO. <b>317-10-8611</b>			
18. <b>332 XI</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Infarction</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>CAROTID ARTERIOSCLEROSIS YEARS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6-27-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CAROTID ENDARTERECTOMY</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 20</b> 19 <b>67</b> to <b>July 1</b> 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 1</b> 19 <b>67</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE <b>William L. Wilkie</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>7-1-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM L. WILKIE</b>		23D. ADDRESS <b>US. Public Health Service Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7/5/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>ARLINGTON NAT'L Cem.</b>	
24D. LOCATION <b>W.W. CHAMBERS F.H. WASH. D.C.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 3 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks, Inc. 1217 St. Paul St.</b>	





T-520

67 6362

BALTIMORE CITY HEALTH DEPARTMENT

67 6362

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MURRAY THOMAS

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1967

1:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

New York

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

New York

D. STREET ADDRESS (If rural, give location)

F.P.O.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
Divorced

8. DATE OF BIRTH

1/14/1924

9. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Alta Vista Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ARTHUR THOMAS

14. MOTHER'S MAIDEN NAME

SINAS SALES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

??

16. SOCIAL  
SECURITY NO.

??

17. INFORMANT

ADDRESS

FINCH &amp; FINCH F.H. ALTA VISTA VA.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Bronchopneumonia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Fatty metamorphosis of liver  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 1, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7/5/67

23C. NAME of CEMETERY or CREMATORY

greenlawn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Pittsylvania, X Va.

24A. DATE REC'D BY HEALTH DEPT.

JUL 3 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks, Inc. 1217 St. Paul St.

WILLIAM B. ROBERTS  
JAMES B. ROBERTS  
JAMES B. ROBERTS  
JAMES B. ROBERTS

WILLIAM B. ROBERTS  
JAMES B. ROBERTS  
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WILLIAM B. ROBERTS  
JAMES B. ROBERTS  
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JAMES B. ROBERTS

# FUNERAL DIRECTOR: IMPORTANT

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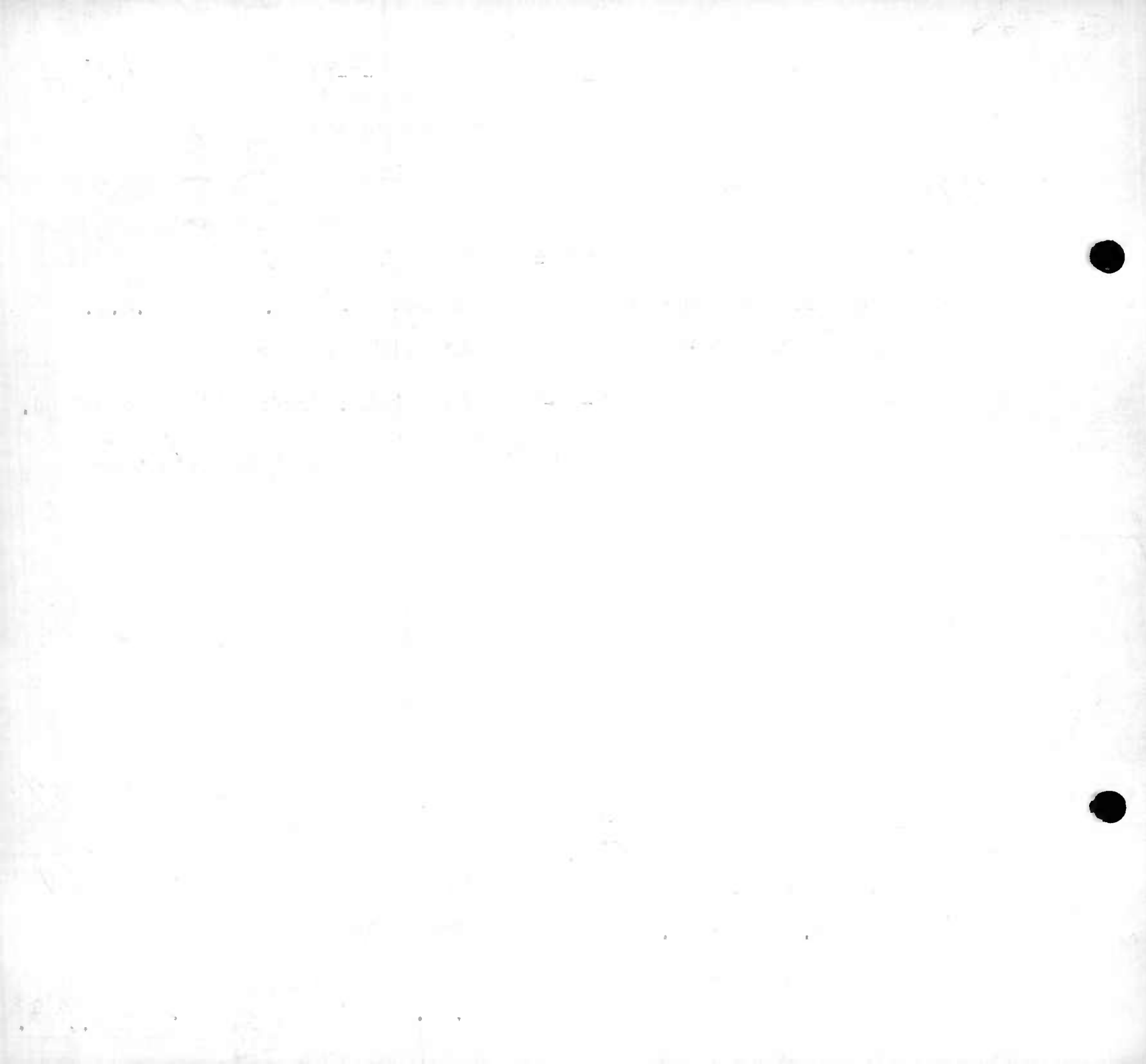
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 6363</span>	
BIRTH NO. <span style="float: right;">67 6363</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		George Blakiston		June 29, 1967 <span style="float: right;">7:05 P.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  Long Green Nursing Home		A. STATE Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City <span style="float: right;">12-01</span>			
		D. STREET ADDRESS (If rural, give location) 100 W. University Parkway			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 2/9/1894	9. AGE (In years lost birthday) 73	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Officer		10B. KIND OF BUSINESS OR INDUSTRY Equitable Trust Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George Blakiston		14. MOTHER'S MAIDEN NAME Price	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1st World War 2nd " "		16. SOCIAL SECURITY NO. 215-07-6043		17. INFORMANT Judge William L. Henderson Gibson Island, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of the Lung DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 9 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1952 to June 29 1967, that (I) (we) last saw the deceased alive on June 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Martin L. Singewald M.D.				23B. DATE SIGNED 6/30/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Martin L. Singewald M.D.		11 E. Chase Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/3/67		St. Thomas	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
Garrison Forest		Henry W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6364		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6364	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Eunice Rathbone Goddard			2. DATE AND HOUR OF DEATH 7-2-1967 11 <sup>00</sup> A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Long Green Nursing Home			A. STATE Massachusetts		
(If not in hospital or institution, give street address or location)			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) New Salem		
			D. STREET ADDRESS (If rural, give location)		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 9/22/1881	9. AGE (In years last birthday) 85	10. UNDER 1 Yr. Months Days Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Professor		10B. KIND OF BUSINESS OR INDUSTRY Goucher College	11. BIRTHPLACE (State or foreign country) New London, Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Willard Goddard			14. MOTHER'S MAIDEN NAME Mary Adeline Thomas		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 021-32-2108		
			17. INFORMANT ADDRESS Miss Miriam Clark 1533 Stonewood Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO <i>Atherosclerosis, generalized</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 to July 2 1967, that (I) (we) last saw the deceased alive on July 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>William G. Helfrich</i> M.D.				23B. DATE SIGNED 7-3-67	
23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich M.D.				23D. ADDRESS 5006 Roland Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 7/3/1967		24C. NAME of CEMETERY or CREMATORY Green Mount	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Md		25A. DATE REC'D BY HEALTH DEPT. JUL 3 1967	
25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Road Balto., Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6365		CERTIFICATE OF DEATH		67 6365	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Taylor Herbert L.		7-2-67 4 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
North Charles General Hospital		Md.		Baltimore	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		13 HORN CRACK	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	Cauc.	Widowed	4-14-90	77 YRS.	United States
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Mech. Eng.		Baltimore & Ohio Railroad		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Henry C. Taylor		Sarah M. MacNabb		No	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
705-07-9746		North Charles General Hospital Chart			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Circosis, liver		long standing	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE - CHRONIC BRONCHITIS			
II		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
Bronchogenic carcinoma					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/30/1967 to 7/2/1967, that (I) (we) lost saw the deceased alive on 7/1/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Badan				7/1/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. J. Gaber		M.D. 5706 Belkona Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/5/1967		New Cathedral	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 3 1967		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

REPORT OF THE COMMISSIONER OF HEALTH  
FOR THE YEAR 1900

ALBANY: J.B. LIPPINCOTT & CO.,  
1901.

PRINTED BY THE COMMISSIONER OF HEALTH.

RECEIVED JAN 10 1901

STATE OF NEW YORK

COMMISSIONER OF HEALTH

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COMMISSIONER OF HEALTH

REPORT OF THE COMMISSIONER OF HEALTH  
FOR THE YEAR 1900



F-652

67 6366

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 6366

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FRANK, IRENE

2. DATE AND HOUR OF DEATH  
JUNE 30, 1967

1:00P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

752 FREDERICK AVE. 21228

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

10/18/95

9. AGE (In years  
lost in day)

71

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM T. DAY

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NONE

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

ST. AGNES HOSPITAL RECORDS

18. 4-20-01

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A)  
DUE TO

cardiac arrest

(B)  
DUE TO

complete heart block

(C)

arteriosclerotic heart disease

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTAINING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JUNE 19 1967 to JUNE 30 19 67,  
that (I) (we) last saw the deceased alive on JUNE 30 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Vincent G. Rubin M.D.

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff ☒  
Phys. ☐

23B. DATE SIGNED

6/30/67

23C. PHYSICIAN'S  
NAME (Type)

VINCENT RUBIN, M.D.

M.D.

23D. ADDRESS

ST. AGNES HOSP RECORDS; CATON &amp; WILKENS AVES.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

BURIAL

7/3/67

WOODLAWN

BALTO CO. MD

JUL 3 1967

Robert E. Farley, M.D.

E. S. McNeil

301 FREDERICK RD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67. 6367				67. 6367		67. 6367	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				WALTER SANGER AYLSWORTH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				July 1, 1967			
D.O.A. Mercy Hospital				Md.			
15. SEX				8. DATE OF BIRTH			
Male				11/14/95			
6. RACE				9. AGE (In years lost birthday)			
White				71			
7. MARRIED, NEVER MARRIED				11. BIRTHPLACE (State or foreign country)			
WIDOWED, DIVORCED (specify)				New Jersey			
Married				12. CITIZEN OF WHAT COUNTRY?			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				USA			
Salesman				10B. KIND OF BUSINESS OR INDUSTRY			
Sun Papers				13. FATHER'S NAME			
Jonas W. Aylsworth				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
Yes				167-07-2675			
17. INFORMANT				ADDRESS			
Mrs Helena Aylsworth				24 E. Madison St. Balt.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				7			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				5			
ANTECEDENT CAUSES				3			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				7			
II				7			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				7			
19A. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				22. I certify that (I) (this hospital) attended the deceased from 3/29/63 to 4/6/67			
22. I certify that (I) (this hospital) attended the deceased from 3/29/63 to 4/6/67				19 to 4/6/67 19			
23A. SIGNATURE				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
25C. FUNERAL DIRECTOR				ADDRESS			
JUL 3 1967				Wm. Cook-Brooks Inc. Baltimore Md. 21202			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6368		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6368	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>John Etter Bailey</i>		2. DATE AND HOUR OF DEATH <i>7-3-67 4:00 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hosp</i>		D. STREET ADDRESS (If rural, give location) <i>5 W. Hill St.</i>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
5. SEX <i>Female</i>		6. RACE <i>Negro</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>SEP.</i>	
8. DATE OF BIRTH <i>7-8-31</i>		9. AGE (In years last birthday) <i>36</i>		10. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>	
11. CITIZEN OF WHAT COUNTRY? <i>USA</i>		12. FATHER'S NAME <i>John H. Morgan</i>		13. MOTHER'S MAIDEN NAME <i>Susie</i>	
14. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		15. SOCIAL SECURITY NO. <i>578-40-5853</i>		16. INFORMANT <i>Jerome H. Bailey</i>	
17. ADDRESS <i>933 W. Fayette St</i>		18. CAUSE OF DEATH <i>Hepatic Coma</i> <i>Cirrhosis of the liver</i>		INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
22. DATE OF OPERATION <i>7-3-67</i>		23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? (Yes or No) <i>No.</i>	
25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
28. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		29. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		30. HOW DID INJURY OCCUR?	
31. I certify that (this hospital) attended the deceased from <i>5-26-67</i> to <i>7-3-67</i> , that (we) last saw the deceased alive on <i>7-3-67</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		32. SIGNATURE <i>William J. Marek</i>		33. DATE SIGNED <i>7-3-67</i>	
34. PHYSICIAN'S NAME (Type) <i>William J. Marek</i>		35. ADDRESS <i>1213 Light St.</i>		36. DATE <i>7/6/67</i>	
37. NAME OF CEMETERY or CREMATORY <i>Baltimore National</i>		38. LOCATION (City, town, or county) <i>Baltimore Md</i>		39. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1967</i>	
40. NAME OF REGISTRAR <i>Robert E. Taylor</i>		41. FUNERAL DIRECTOR <i>Charles A. Rice</i>		42. ADDRESS <i>661 W. Barre St</i>	

ADU

See page 100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6369				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6369	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				ROBERT HARRIS		JUNE 27 1967 7:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
UNIVERSITY HOSPITAL				MD. U.S.A.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE		22-02	
				D. STREET ADDRESS (If rural, give location)			
				628 PORTLAND ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
M	NEGRO	on	5/12/12	55	U.S.A.	Littleton, N.C.	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
LABOR				Littleton, N.C.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
SIDNEY HARRIS				IRMA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Manie B Harris		322 Lyman Pl. Plainfield N.J.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) 2 MYOCARDIAL INFARCTIONS - CHF			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from June 26 19 67 to June 27 19 67, that (1) (we) last saw the deceased alive on JUNE 27 19 67 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
William H. Farley, Sr.				6/27/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
WILLIAM							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/2/67		Harris		Littleton, N.C.	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 5 1967		Robert E. Farley		Charles Rice		6614 Barre St.	

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1  
5-413

67 6370

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6370

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MANUEL SALVADORE

2. DATE AND HOUR PRONOUNCED DEAD

June 28, 1967 10:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3800 Calloway Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan 22 1937

9. AGE (In years  
last birthday)

30

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Bus Boy

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Balto. Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Victor Salvador

14. MOTHER'S MAIDEN NAME

Ebbie Fallin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-34-1474

17. INFORMANT

Gloria Johnson 1615 N. Bentley St

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebrocranial injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
6-19-67 2:00 A.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7/3/67

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

Balto. Md

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 5 1967

24B. NAME OF REGISTRAR

Robert E. Fadden, M.D.

24C. FUNERAL DIRECTOR

Earl Gilmore 1827 W. North Ge

ADDRESS

WILLIAM HODGE

2000 Ave. 60th St.

St. Louis, Mo.

June 10, 1900

Dear Sir:

I have

received

your

letter

of

the

10th

inst.

and

am

very

glad

to

hear

from

you.

I

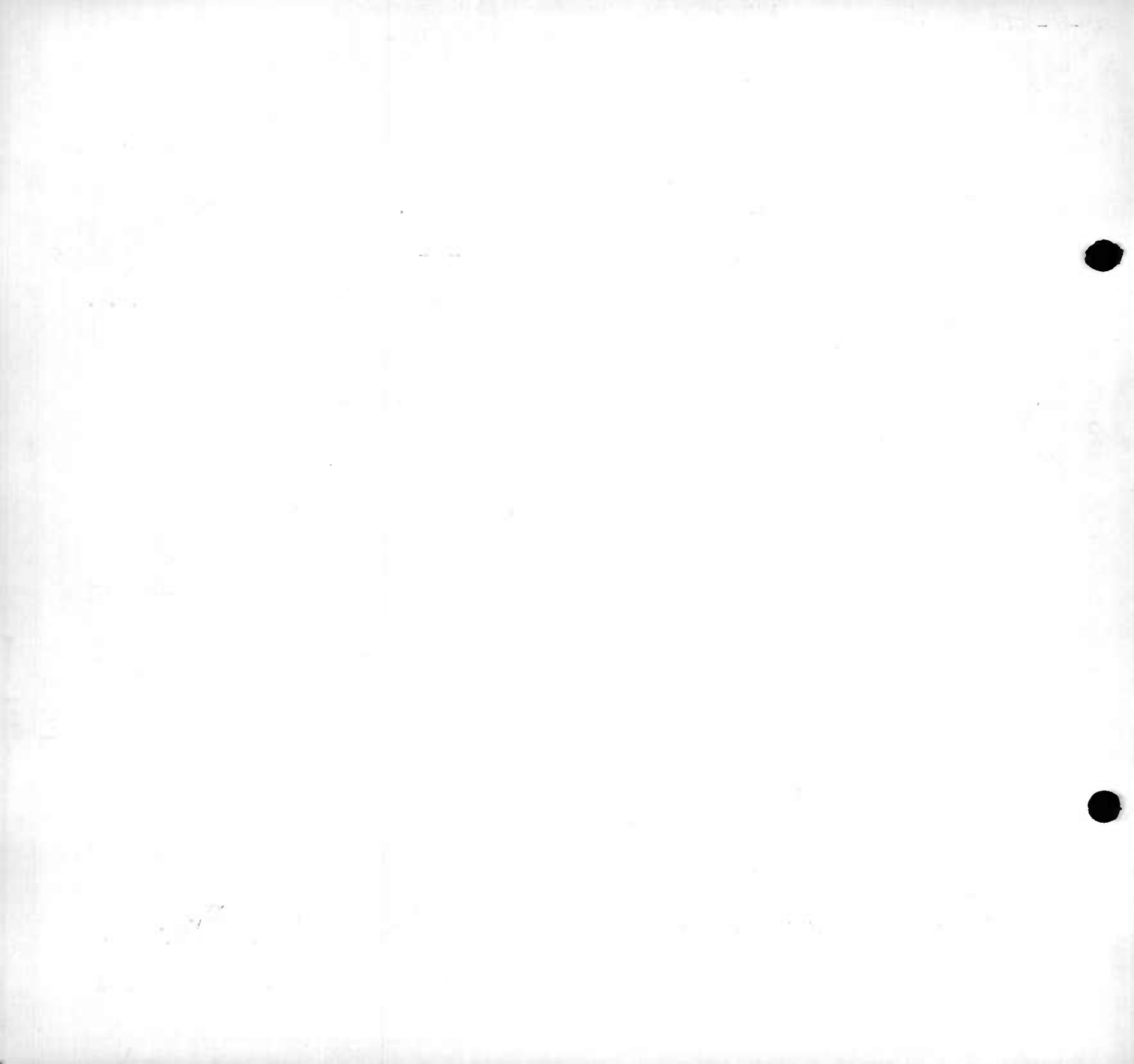
am

49-60-50TN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-400 BIRTH NO. 67-12455 67 6371		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6371 4	
M.E. CASE NO. 1. NAME OF DECEASED (Type as Print) <b>BABY GIRL GERALDINE POWELL</b>			2. DATE AND HOUR OF DEATH <b>6-29-67</b> 1:25 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>414 E. 22nd STREET 21218</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED <b>SINGLE</b>	8. DATE OF BIRTH <b>6-29-67</b>	9. AGE (In years last birthday) <b>6</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <b>55</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>JERRY</b>		
14. MOTHER'S MAIDEN NAME <b>COLEMAN</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>BCH:RECORDS 4940 EASTERN AVENUE 21224</b>		
18. <b>776X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>immaturity</b> <b>no intracerebral hemorrhage</b> <b>no atelectasis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>since birth</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat. While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-29 at 6 AM</b> 19 <b>67</b> to <b>6-29</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-29</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. McHugh</b>				23B. DATE SIGNED <b>6-29-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. E. MC HUGH</b>				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO. MD. 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>6-30-67</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore City Hospitals</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21224</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HOSPITAL DISPOSAL</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 67-12456 67 6372		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) DOWNEY, B. Boy		2. DATE AND HOUR OF DEATH 6/28/67 2:47 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 1717 Aiken St. #21213	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never Married	8. DATE OF BIRTH 6-28-67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 5
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? 3	
13. FATHER'S NAME Not known		14. MOTHER'S MAIDEN NAME Rose Marie Downey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT BCH 4940 Eastern Avenue		ADDRESS RECORDS: Baltimore, Maryland #21224	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Prematurity	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) 28 wks gestation	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/28 19 67 to 6/28 19 67, that (I) (we) last saw the deceased alive on 6/28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE JEROLD YECIES M.D.		23B. DATE SIGNED 6/28/67	
23C. PHYSICIAN'S NAME (Type) JEROLD YECIES M.D.		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6-29-67	
24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224	
25A. DATE RECEIVED BY HEALTH DEPT JUL 5 1967		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR		HOSPITAL DISPOSAL ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

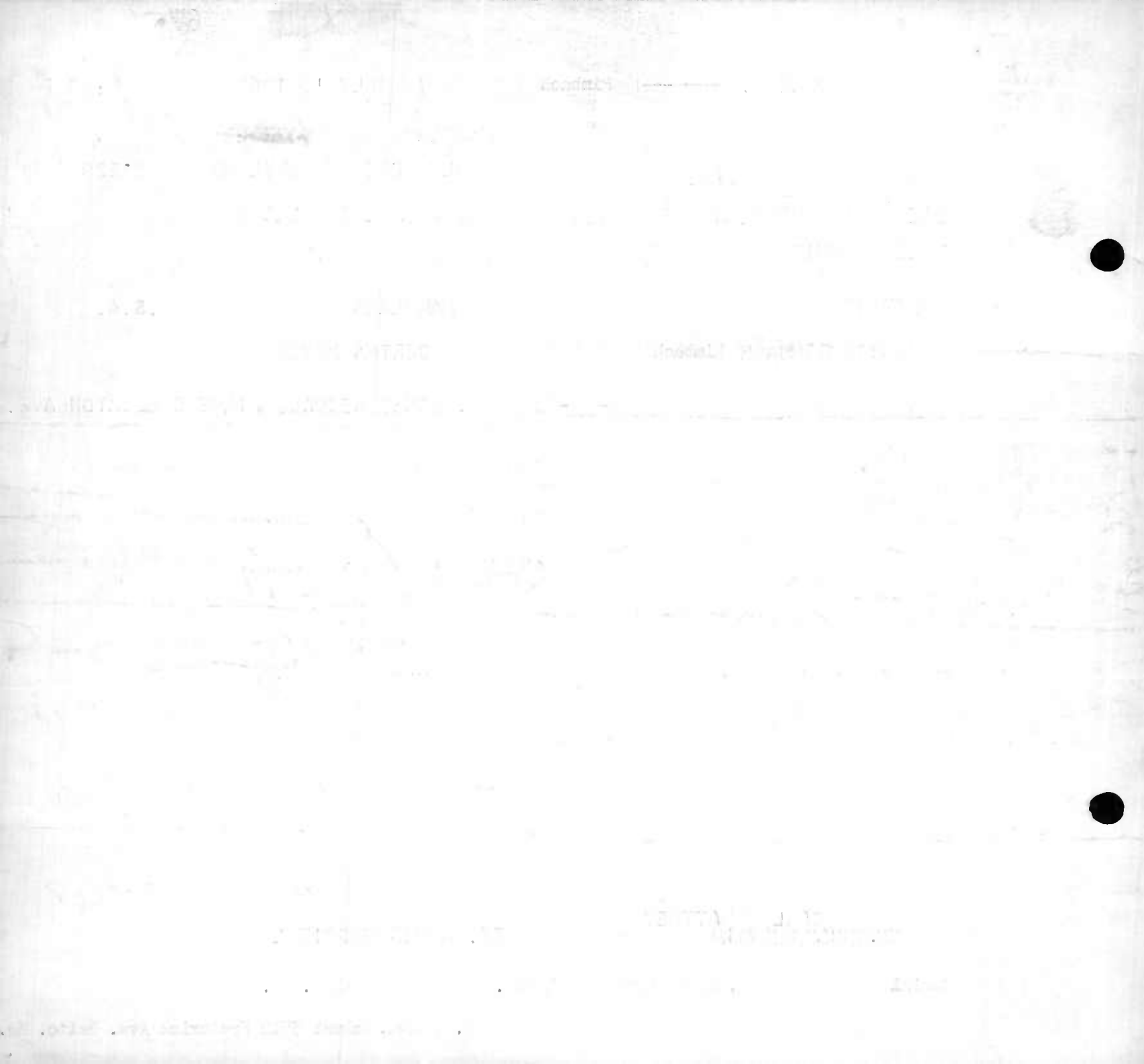
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6373	
BIRTH NO. 67 6373		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Mary Markowski</i>		2. DATE AND HOUR OF DEATH <i>July - 2 - 1967</i> <i>9P</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>City</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>1934 Eastern Ave.</i>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balt. City</i> <i>2-01</i>	
5. SEX <i>M.</i>		6. RACE <i>W.</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	
8. DATE OF BIRTH <i>5-3-1895</i>		9. AGE (In years last birthday) <i>72</i>		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Joseph</i>		14. MOTHER'S MAIDEN NAME <i>Wink</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>220-059211</i>		17. INFORMANT <i>Alexander Markowski</i>	
18. <i>420.1 I</i>		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Coronary Thrombosis</i>		<i>Instantaneous</i>	
ANTECEDENT CAUSES		(B) <i>Hypertensive C.V. Disease</i>		<i>16 years</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 20</i> 19 <i>57</i> to <i>7/2</i> 19 <i>67</i> , that (I) <del>we</del> lost saw the deceased alive on <i>6/12</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Henry J. Houska</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7/3/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>HENRY J. HOUSKA</i>		23D. ADDRESS <i>333 S. East Ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<i>Buried</i>		<i>July 6 - 67</i>		<i>Holy Rosary</i>	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR			
<i>German Hill Rd</i>		<i>T. Fisher</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>1930 Eastern Ave.</i>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
GEORGE E. REMBACH Rimbach		JULY 1, 1967		7:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
SAINT AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229		MARYLAND CARROLL 25-41			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
BALTIMORE		MARYLAND 21229			
341 OAKLEE VILLAGE					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	WIDOWER	06/10/85	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
GEORGE REMBACH Rimbach		BERTHA MEYERS		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		216-01-1016		ST. AGNES RECORDS WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Pulmonary edema. DUE TO Aspiration gastric contents (B) DUE TO Peptic ulcer Duodenum. Gastric ulcers Multiple (C) DUE TO		6 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Coronary Arteriosclerosis + Nephrosclerosis			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
6-23-1967	Leading duodenal ulcer	YES	YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (X) (this hospital) attended the deceased from 6/22 1967 to 7/11 1967, that (X) (we) last saw the deceased alive on 7/11 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXXX) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
CARL H. MATTHEY				7-2-1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
CARL H. MATTHEY		ST. AGNES HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	July 5, 1967	Loudon Park Cem.	Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
JUL 5 1967	Robert E. Farley, M.D.	G. Truman Schwab 3512 Frederick Ave. Balto. Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6375		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6375	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Schreibet, Emma P.</i>				2. DATE AND HOUR OF DEATH <i>July 1, 1967 6:45 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Balto. City Hospitals</i> 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE <i>Md.</i> B. COUNTY <i>26-08</i>			
5. SEX <i>Female</i>				6. RACE <i>White</i>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>				8. DATE OF BIRTH <i>6/13/92</i>			
9. AGE (In years last birthday) <i>75</i>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>			
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Jan Ziolkowski</i>				14. MOTHER'S MAIDEN NAME <i>Constance Ziemicka</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>none</i>				16. SOCIAL SECURITY NO. <i>none</i>			
17. INFORMANT <i>BCH:RECORDS 4940 EASTERN AVENUE</i>				ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH <i>&gt; 3 wks.</i>			
19A. DATE OF OPERATION <i>2</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <i>YES</i>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6/29</i> 19 <i>67</i> to <i>7/1</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5-7-1-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Stewart Leibowitz</i>				23B. DATE SIGNED <i>July 1, 1967</i>			
23C. PHYSICIAN'S NAME (Type) <i>DR. STEWART LEIBOWITZ</i>				23D. ADDRESS <i>BALTIMORE CITY HOSPITALS</i> 4940 EASTERN AVENUE BALTO. MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>7/5/67</i>			
24C. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1967</i>				25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>			
25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i> 2601 E. Madison St.				ADDRESS			

2nd March 1944

Dear Mr. [illegible]

I have your letter of 1st March and am sorry to hear that you are not well.

I am sure you will get better soon.

I am, Sir, very truly yours,

[illegible signature]

[illegible name]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

[illegible address]

Yours faithfully,

[illegible signature]

[illegible name]

[illegible address]

[illegible address]

[illegible address]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6376		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6376	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RUBY, CHESTER T.		2. DATE AND HOUR OF DEATH 2 JULY 1967 12:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 7-02 D. STREET ADDRESS (If rural, give location) 801 NORTH ROSE STREET			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 1 JULY 1902	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COORDINATOR		10B. KIND OF BUSINESS OR INDUSTRY Maryland Apts. Inc. REAL ESTATE		11. BIRTHPLACE (State or foreign country) MARYLAND Balto.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ERSON RUBY		14. MOTHER'S MAIDEN NAME VIOLA PATTERSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN yes-navy 215-10-3702		16. SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS Margaret Redgrave Ruby, wife, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PULMONARY EMBOLUS		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO CORONARY THROMBOSIS (B) DUE TO ARTERIOSCLEROSIS (C)		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 10 DAYS 10 YEARS	
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N.A.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N.A.	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N.A.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> N.A.		21F. HOW DID INJURY OCCUR? N.A.	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from 1 JULY 1967 to 2 JULY 1967, that (I) <del>(we)</del> last saw the deceased alive on 2 JULY 1967 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2 July 1967	
23C. PHYSICIAN'S NAME (Type) PARK W. ESPENSCHADE JR.		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/67		24C. NAME OF CEMETERY or CREMATORY Moreland Mem. Park	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. STATE (State) Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1967	
25B. NAME OF REGISTRAR Robert E. Fairley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			

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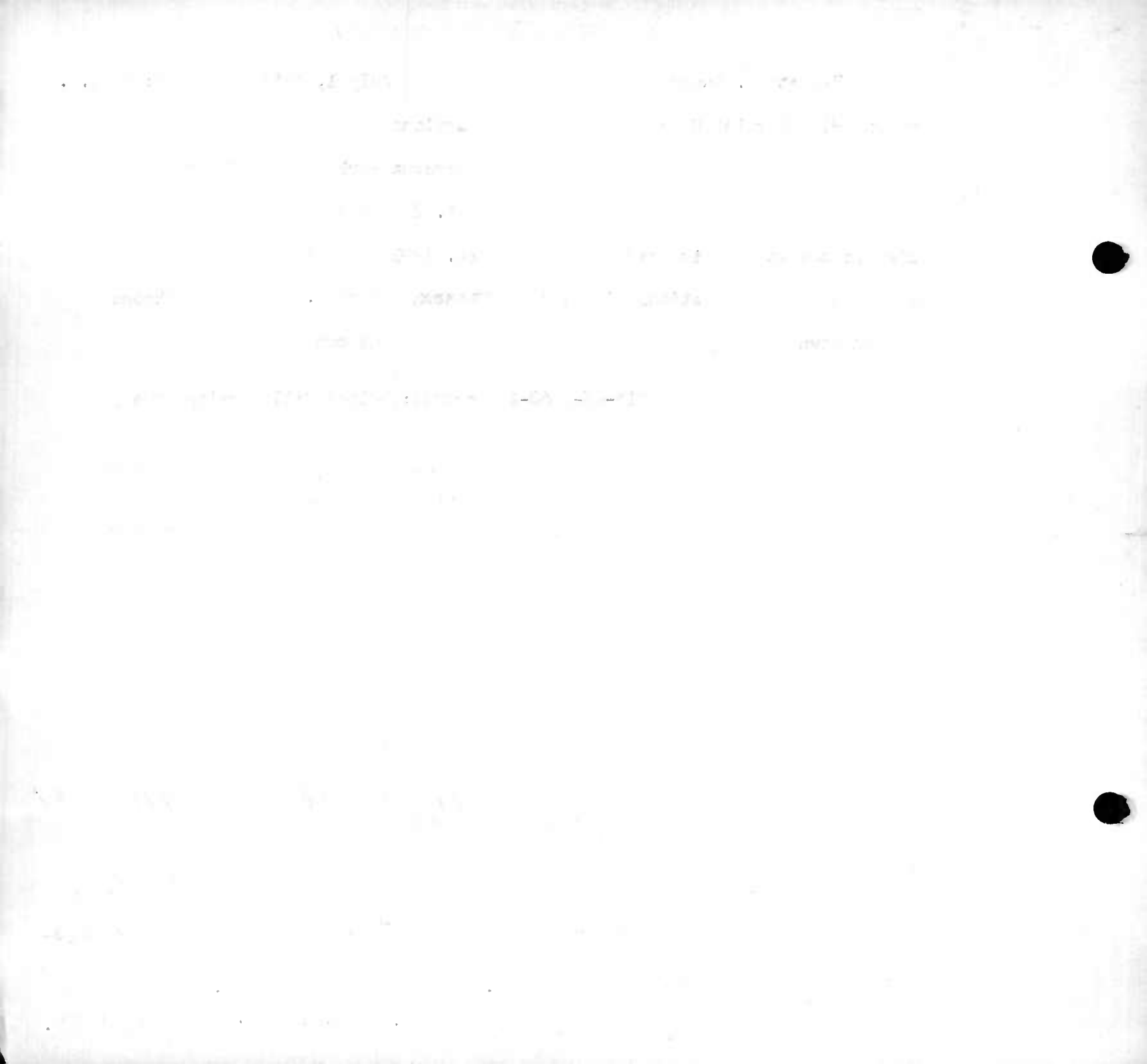
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6377	
BIRTH NO.		67 6377		CERTIFICATE OF DEATH	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Everett M. Hawes		2. DATE AND HOUR OF DEATH July 1, 1967 5:30 A.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Bolton Hill Nursing Home		A. STATE Maryland		B. COUNTY 99	
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Sovereign Park 52-00	
		D. STREET ADDRESS (If rural, give location)		Rt. 2 Box 284	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days Hours Min.
Male	Caucasian	Divorced	Dec. 1901	65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Die Smith		National Plastics		Unknown (Mass.)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
unknown		unknown		Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-05-7660-A		17. INFORMANT Records: Bolton Hill Nursing Home	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Severe generalized suppurative arthritis</i>		<i>years</i>	
ANTECEDENT CAUSES		(B) <i>arteriosclerotic heart disease</i>		<i>years</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/11</i> 19 <i>66</i> to <i>7/1</i> 19 <i>67</i> . that (I) (we) last saw the deceased alive on <i>7/1</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>ALLAN H. MACHT</i> M.D.				23B. DATE SIGNED <i>7/1/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MACHT</i> M.D.				23D. ADDRESS <i>2 E. READ ST. 21202</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7/5/67		Glen Haven Mem. Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 5 1967		<i>Robert E. Taylor, M.D.</i>		JOHN F. DENNY, INC. 715 Light St.	
24D. LOCATION (City, town, or county) (State)		Glen Burnie, Md			





5-516

67 6378

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 6378

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
George Schoenberger		June 30, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Muncy Hospital		A. STATE Balto. Maryland	
(If not in hospital or institution, give street address or location)		B. COUNTY 26-09	
		C. CITY OR TOWN Balto.	
		D. STREET ADDRESS 3806 Foster Ave. 21224	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-15-1897
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 70
13. FATHER'S NAME Philip		11. BIRTHPLACE (State or foreign country) Balto. County, Md	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I 5-6-1918 - 8-5-1919		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO. 216-10-4333		14. MOTHER'S MAIDEN NAME —	
17. INFORMANT Mrs. Mary Schoenberger		ADDRESS 3806 Foster Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.) Bronchogenic Ca & undiagnosed metastasis		INTERVAL BETWEEN ONSET AND DEATH 3 mos -	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO	
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/28 1967 to 6/30 1967, that (I) (we) last saw the deceased alive on 6/30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE E Lee Robbins		23B. DATE SIGNED 6/30/67	
23C. PHYSICIAN'S NAME (Type) F. Lee Robbins		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-1967	
24C. NAME OF CEMETERY or CREMATORY Balto Nat.		24D. LOCATION (City, town, or county) (State) Md.	
25A. DATE RECEIVED JUL 5 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Thelma A. Hoffmann		ADDRESS 3218 Hydam	

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BIRTH NO. 67 6379

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6379

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>JEROME LEROY SELLMAN</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>July 3, 1967</b> <b>8:45 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>320 N. Paca Street</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>4-02</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>320 N. Paca Street</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>11/6/1914</b>		9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George E. Sellman</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Welsh</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes ?</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>Richard Sellman 2012 Hillside Dr.</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Heart Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D. EXAMINER'S NAME (Type)							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>7/6/1967</b>		23C. NAME of CEMETERY or CREMATORY <b>Lorraine Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		24C. FUNERAL DIRECTOR ADDRESS <b>John T. Stansbury Woodlawn, Md.</b>			

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

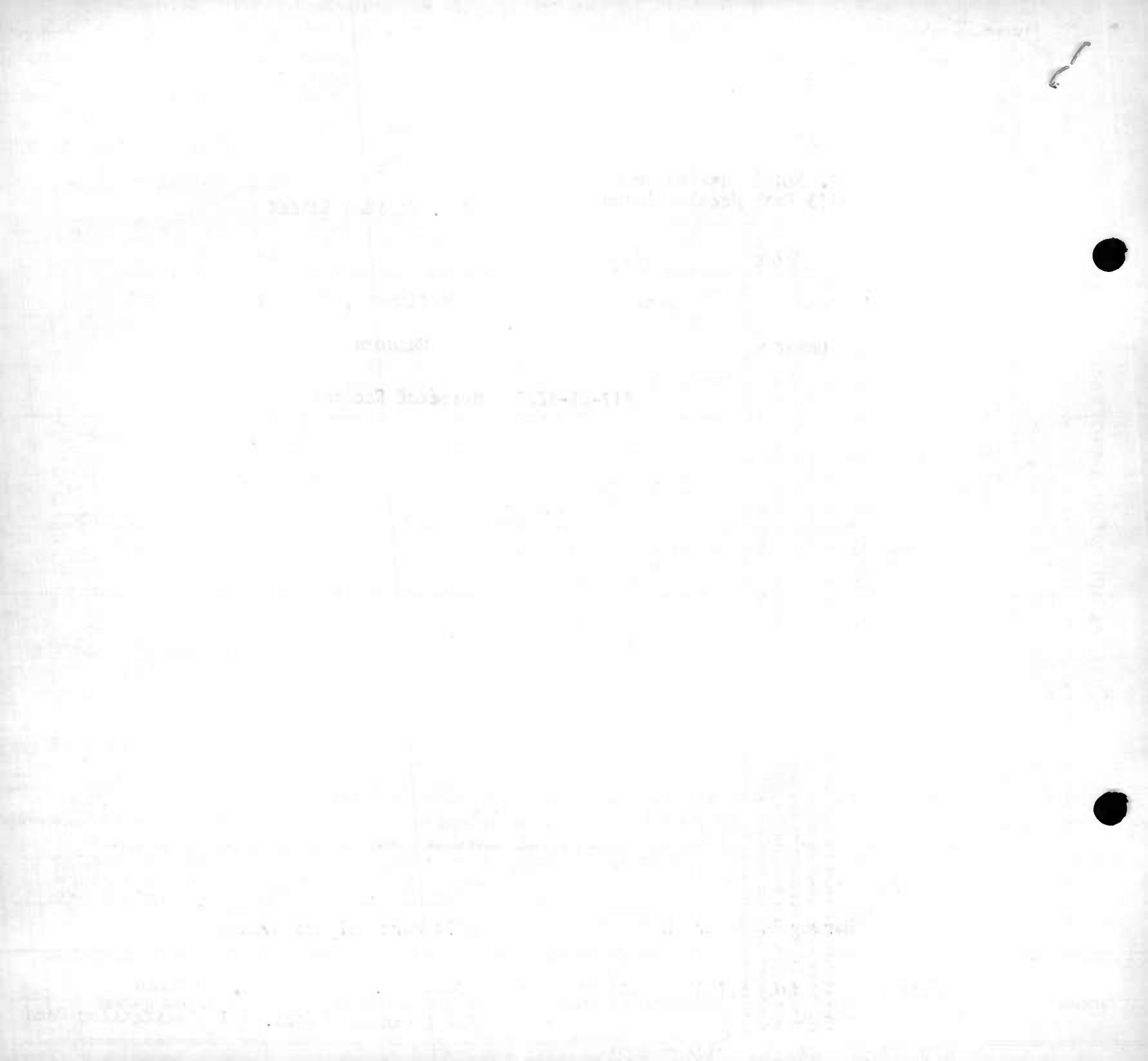
Administrative  
Investigation

Continuation of Report

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6380	
BIRTH NO. 67 6380		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>EUGENIA GERSON</b>			2. DATE AND HOUR OF DEATH <b>JULY 3, 1967</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Mt. Sinai Nursing Home 4613 Park Heights Avenue</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>11-02</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>9 W. Preston Street</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	B. DATE OF BIRTH	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-05-8269</b>	17. INFORMANT ADDRESS <b>Hospital Records</b>		
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10405</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) lost saw the deceased alive on <b>7/2/67</b> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harvey S. Feuerman</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>7/3/67</b>
23C. PHYSICIAN'S NAME (Type) <b>Harvey S. Feuerman</b>			23D. ADDRESS M.D. <b>6210 Park Heights Avenue</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 5, 1967</b>	24C. NAME of CEMETERY or CREMATORY <b>Baltimore Hebrew Belair Rd.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Sol Levinson &amp; Bros. 6010 Reisterstown Road</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6381		CERTIFICATE OF DEATH		67 6381	
1. NAME OF DECEASED (Type or Print) <b>ANNIE FARBER</b>			2. DATE AND HOUR OF DEATH <b>6-29-67</b> # <b>8:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Simai Hospital of Baltimore</b> <b>Greenway at Belvedere</b> <b>Balto, MD</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>27-18</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
			D. STREET ADDRESS (If rural, give location) <b>4841 REISTERSTOWN Rd</b> #15		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12-4-88</b>	9. AGE (In years lost birthday) <b>78</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ABRAHAM ISAACS</b>		14. MOTHER'S MAIDEN NAME <b>REVA ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. MAX FARBER, 4841 REISTERSTOWN ROAD</b>	
18. <b>42211-260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CHF</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>			CAUSE OF DEATH <b>CHF</b> <b>ASCVD</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b> <b>Diabetic Mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>6-17-67</b> 19 to <b>6-29-67</b> , that (I) (we) last saw the deceased alive on <b>6-29-67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Shenman</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-29-67</b>
23C. PHYSICIAN'S NAME (Type) <b>VENTURAKIS A</b>			23D. ADDRESS <b>Simai Hospital 7 Baltimore</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7/2/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>GREATER BALTIMORE LODGE</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber, MD</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTE., RD.</b>			

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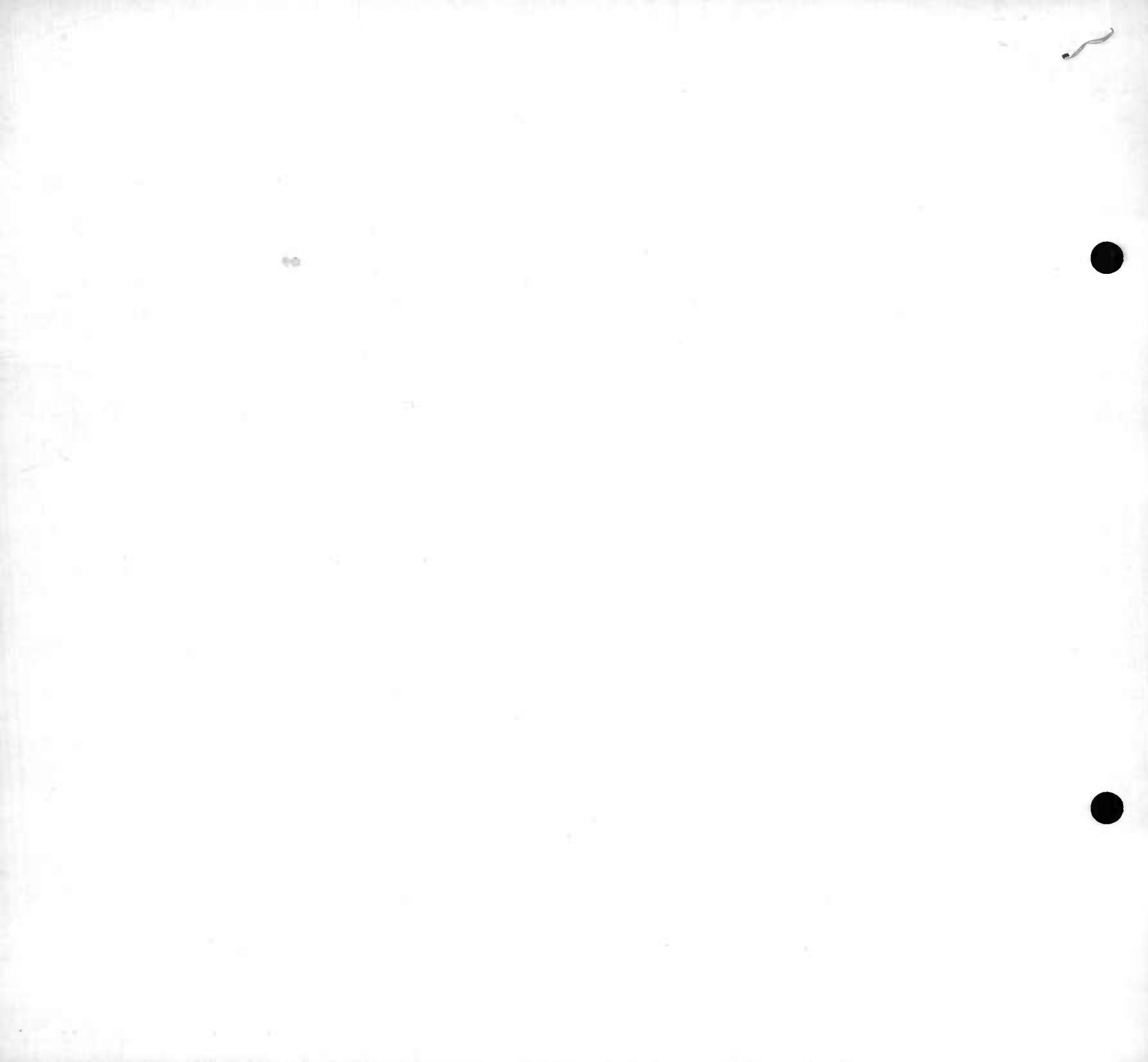
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FUNERAL DIRECTOR: IMPORTANT

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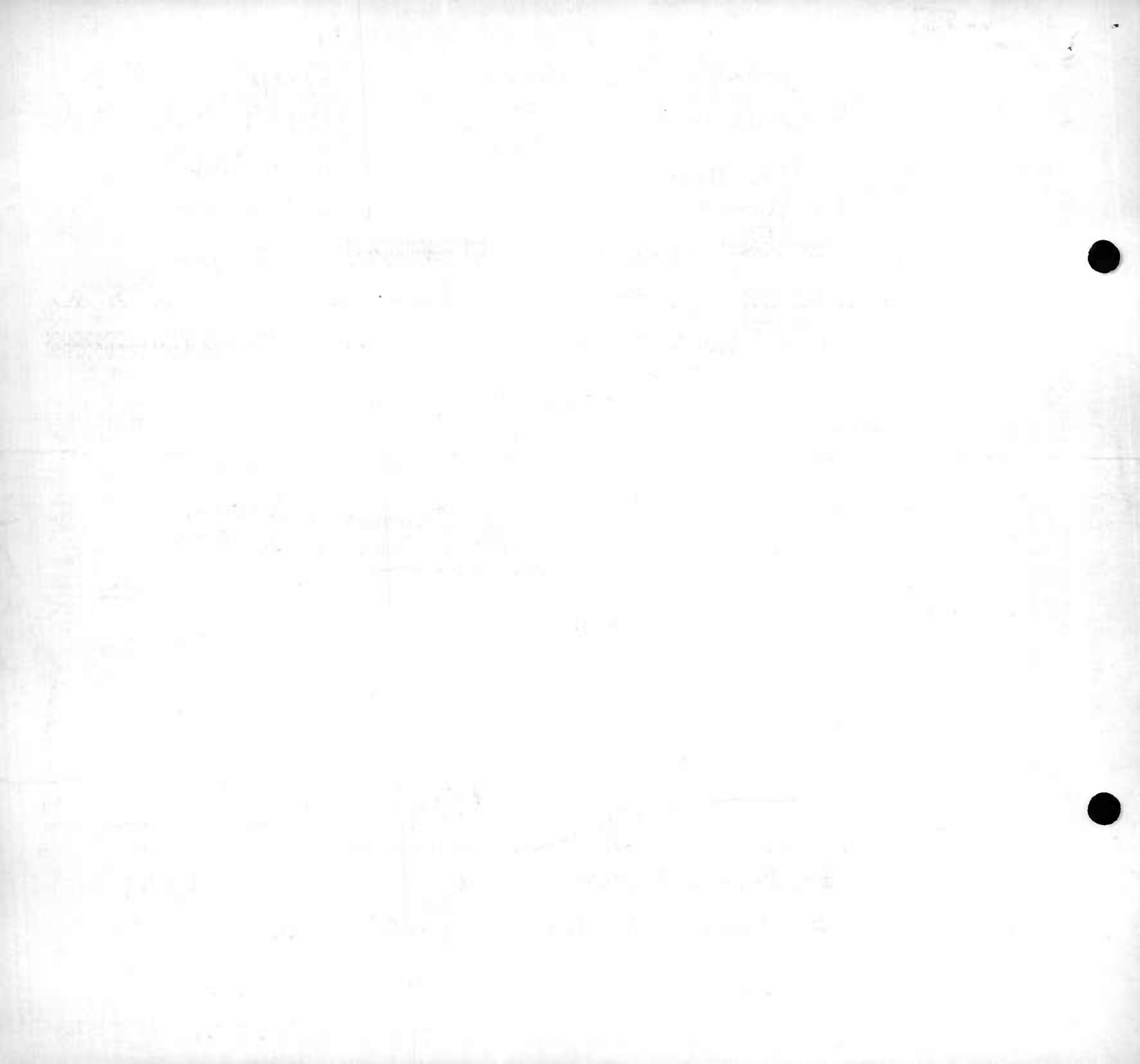
67 6382		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6382	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
DORA K. FRIEDMAN		JUNE 30, 1967		1 6 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
MT. SINAI NURSING HOME		MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		3814 BANCROFT ROAD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	WHITE	WIDOWED		85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		LITHUANIA	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
USA		SOLOMON KRAMER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				MISS CELIA FRIEDMAN, 3814 BANCROFT ROAD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.)		(A) Pneumonia			
ANTECEDENT CAUSES		(B) Arteriosclerotic cardiovascular disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Generalized arteriosclerosis			
II		INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		1 month			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (This hospital) attended the deceased from 1966 to June 30, 1967, that (I) last saw the deceased alive on June 27, 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
DR. SEYMOUR RUBIN				6/30/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				5415 PARK HEIGHTS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		7/2/67		HEBREW YOUNG MEN	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 5 1967		Robert E. Fisher, M.D.		SOL LEVINSON & BROS. INC., 6010 REIST., RD.	



**FUNERAL DIRECTOR: IMPORTANT**

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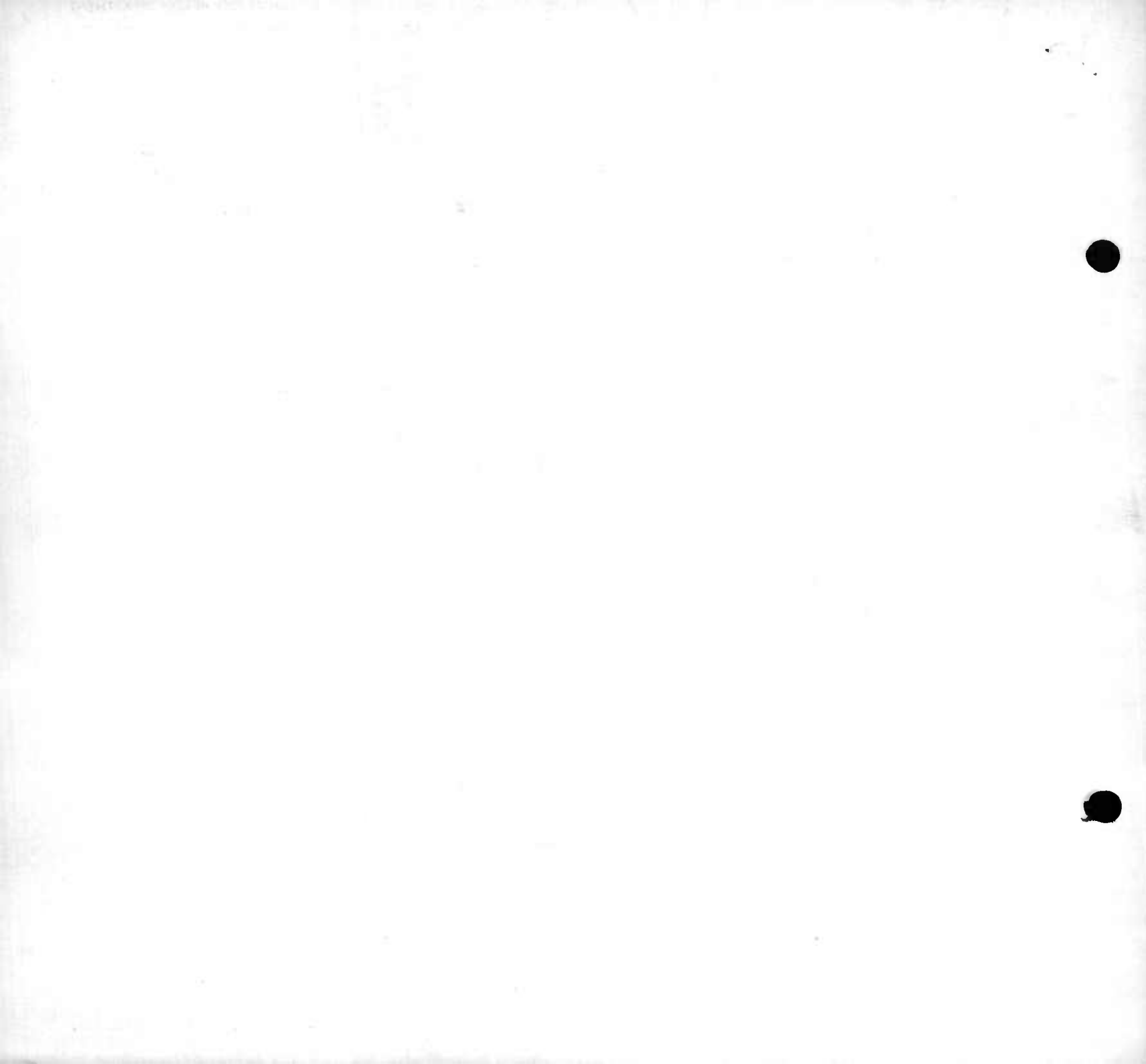
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6383	
BIRTH NO. 55		67 6383	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Joseph Fishman</b>	
2. DATE AND HOUR OF DEATH <b>6/30/67 5 P.</b>		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>Belvedere House of the Pines</b>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>Baltimore Md</b> B. COUNTY <b>3404 Keston Rd</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Belvedere House of The Pines</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Md - 53-00</b>	
D. STREET ADDRESS (If rural, give location) <b>3404 Keston Rd</b>			
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>6/30/1934</b>
9. AGE (In years last birthday) <b>33 yrs</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR</b>	10B. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>	11. BIRTHPLACE (State or foreign country) <b>Russia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Northan FISHMAN</b>		14. MOTHER'S MAIDEN NAME <b>TATELBAUM</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-09-4891</b>	
17. INFORMANT <b>MR. BENJAMIN FISHMAN, 6200 PIMLICO ROAD</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive Art. Sele notic Vascular Disease</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>none</b>			
19A. DATE OF OPERATION <b>6/29</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (This hospital) attended the deceased from <b>6/25</b> 19 <b>67</b> to <b>6/29</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/29</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Dr. Herman Seidel</b>		23B. DATE SIGNED <b>6/30/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Herman Seidel</b>		23D. ADDRESS <b>2404 E. Entaw Pl</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7-2-67</b>	
24C. NAME of CEMETERY or CREMATORY <b>KNESSETH ISRAEL KOLK WOLYN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>		ADDRESS <b>6010 REISTERSTOWN</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6384				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6384	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>FANNIE G. BERESONSKY</b>		2. DATE AND HOUR OF DEATH <b>JULY 1, 1967</b> <span style="float: right;">3 P. M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3801 Strathmore Ave.</b>				A. STATE <b>Maryland</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>3801 Strathmore Ave.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH		9. AGE (In years lost birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wolf Weinberg</b>				14. MOTHER'S MAIDEN NAME <b>Mildred ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph Beresonsky -- Same</b>		ADDRESS	
18. <b>153.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Calcium Metastases Heart</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>7-1-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>7-1-67</b> that (I) (we) last saw the deceased alive on <b>7/1/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dr. Milton Kirsh</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>7-1-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. MILTON KIRSH</b>				23D. ADDRESS <b>4000 W. Northern Parkway</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7/2/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Beth Jacob Con. Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Finksburg, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS INC. 6010 Reist Rd.</b>			



47-19-83

K-512

67 6385

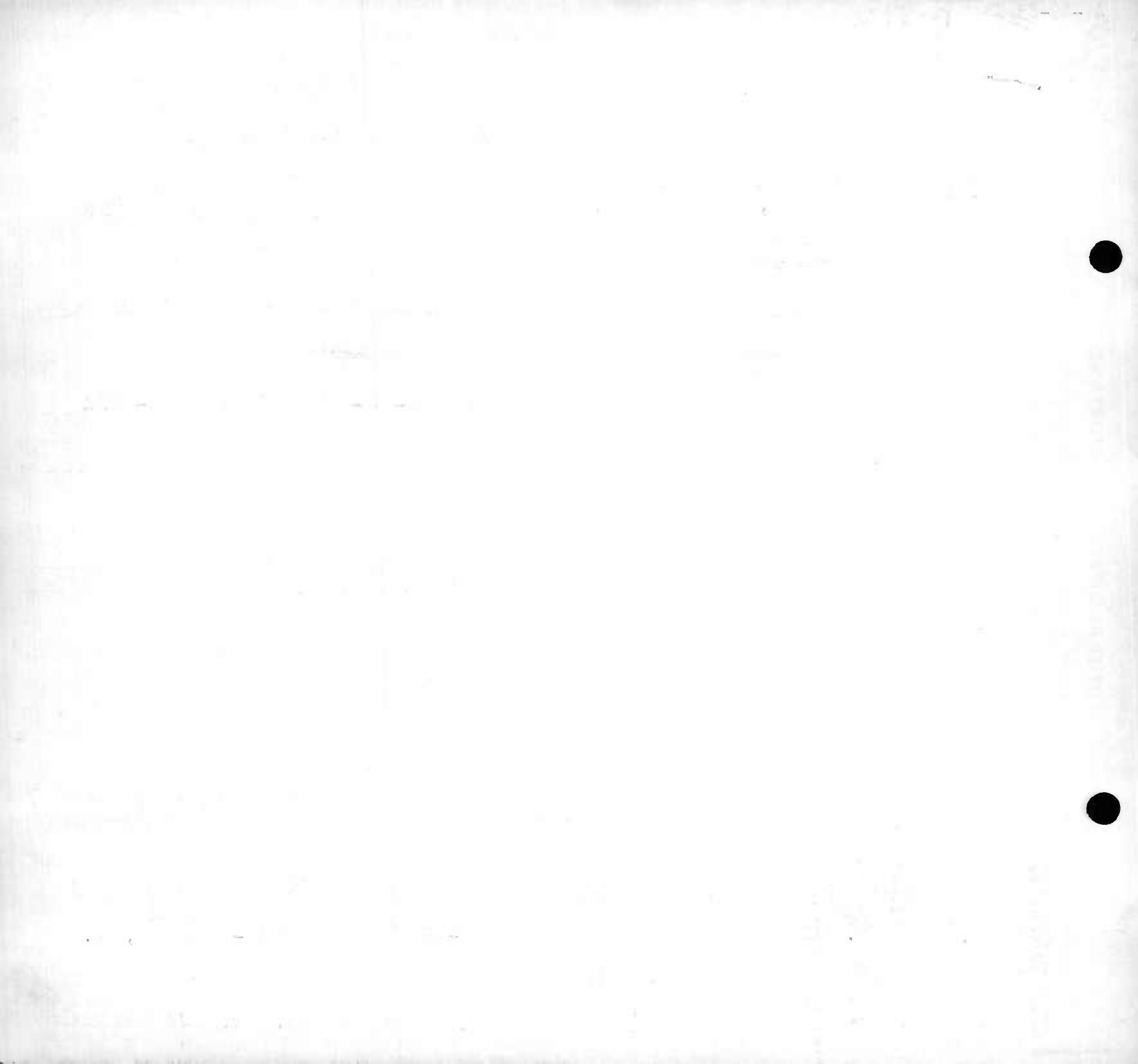
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 6385

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Rose Kanefsky</i>		2. DATE AND HOUR OF DEATH <i>7/1/67 19:20 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> <i>27-20</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND #21224</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
D. STREET ADDRESS (If rural, give location) <i>3100 Bonnie Rd #21208</i>							
5. SEX <i>Female</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>11/1/15</i>	9. AGE (In years last birthday) <i>51</i>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND, BALTIMORE</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>HYMAN PROSTIC</i>				14. MOTHER'S MAIDEN NAME <i>EVA <del>XXXX</del> FUCHSMAN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>RECORDS-BCH-4940 EASTERN AVENUE-21224</i>			
18. <i>336.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO <i>Pulmonary Embolus, suspected</i> (B) DUE TO <i>Asymptomatic lateral sclerosis</i> (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i> <i>15 min</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5/3/1967</i> to <i>7/1/1967</i> , tho (I) (we) last saw the deceased alive on <i>7/1/67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Neil R. Williamson</i> M.D.				23B. DATE SIGNED <i>7/1/67</i>		23C. PHYSICIAN'S NAME (Type) <i>DR. NEIL WILLIAMSON</i>	
23D. ADDRESS <i>BCH-4940 EASTERN AVENUE-BALTIMORE, MD.</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 3/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Bnai Israel</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Sal. Levinson &amp; Bros. Inc. 6010 Reisterstown Rd</i>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

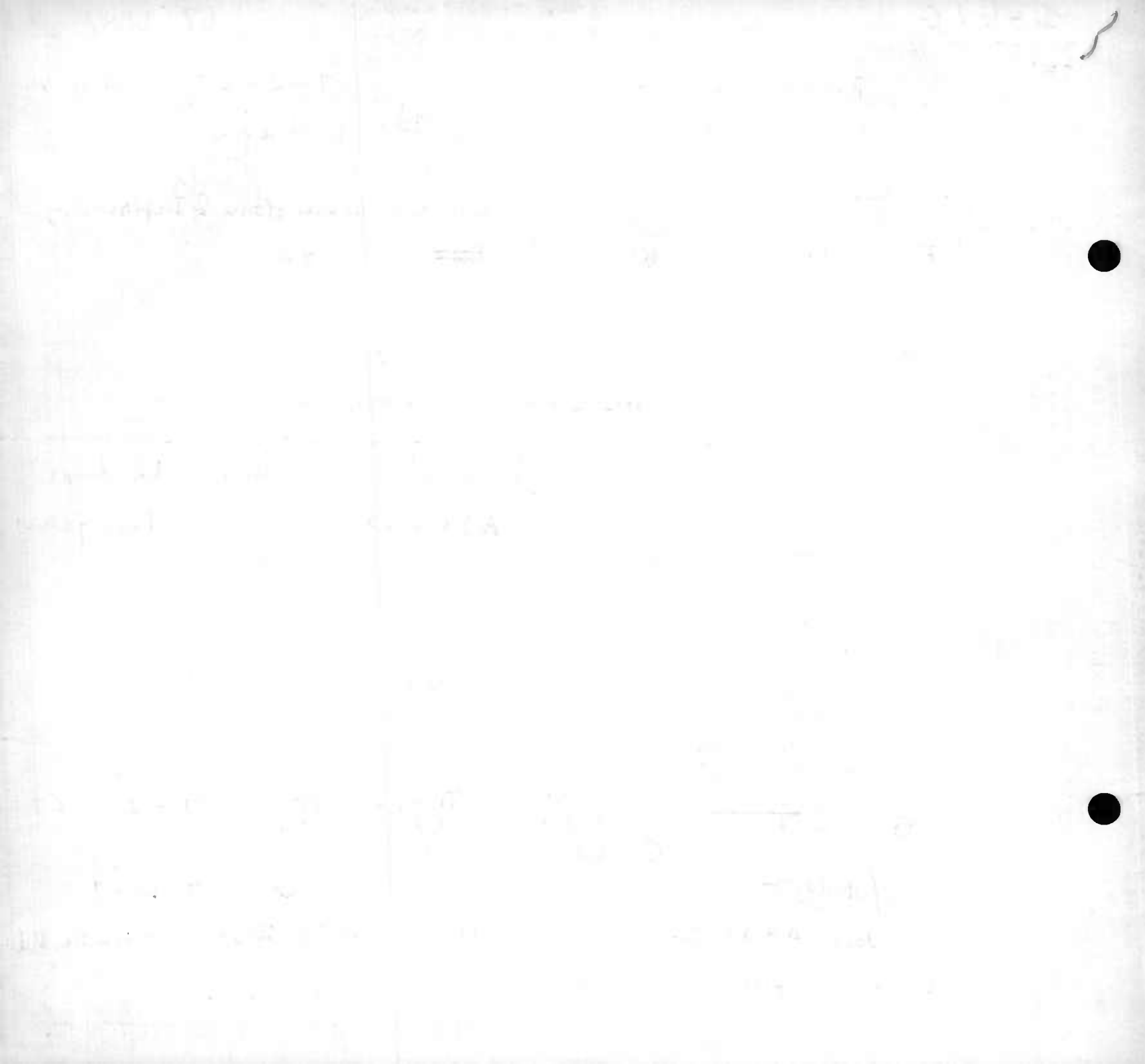
Baltimore City Health Department				Registered No. 67 6386	
BIRTH NO. 67 6386		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROSE MATRICK		2. DATE AND HOUR OF DEATH JUNE 30, 1967 11 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-15		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 90 BELVEDERE NURSING HOME 2525 W. BELVEDERE AVENUE		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 2215 ROGENE DRIVE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 62	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME BORIS FRANTZ		14. MOTHER'S MAIDEN NAME KATE PEARLMAN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. FLORENCE SNYDER, 2215 ROGENE DRIVE	
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) acute cerebral thrombosis DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from 5/10 1967 to 6/30/67 that (I) <del>(we)</del> last saw the deceased alive on 6/29/67 19 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did not)</del> view the body after death.					
23A. SIGNATURE Mehsini		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/1/67	
23C. PHYSICIAN'S NAME (Type) DR. MILTON KIRSH		23D. ADDRESS M.D. 4000 W. NORTHERN PARKWAY			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE July 4/67		24C. NAME OF CEMETERY or CREMATORY Montifiore	
24D. LOCATION Philadelphia, Pa.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1967			
25B. NAME OF REGISTRAR R. E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REIST., RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6387</b>	
BIRTH NO. <b>67 6387</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <b>1. NAME OF DECEASED</b> (Type or Print) <b>Rebecca GERBER</b>			2. DATE AND HOUR OF DEATH <b>7-2-67 4:10 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>91 Levindale Home</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 37-17</b> D. STREET ADDRESS (If rural, give location) <b>Levindale Hebrew Home &amp; Infirmary</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <del>XXXX</del>	9. AGE (In years lost birthday) <b>80</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>218-54-0120</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>
18. <b>42211</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>			CAUSE OF DEATH <b>BRONCHOPNEUMONIA</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>12 years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-1-1955</b> to <b>7-2-1967</b> , that <b>(I)</b> (we) lost saw the deceased alive on <b>7-2-1967</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (We) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Ardaiz</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>7-2-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jose ARDAIZ</b>				23D. ADDRESS M.D. <b>5912 Cross Country Blvd. Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7/4/67</b>		24C. NAME of CEMETERY or CREMATORY <b>BNAI ISRAEL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS 6010 REISTERSTOWN RD.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6388</b>	
BIRTH NO. <b>67 6388</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Milton John Woolley</b>		2. DATE AND HOUR OF DEATH <b>7-1-67 2:35 AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		A. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-10</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP.</b>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>city</b>	
		D. STREET ADDRESS (If rural, give location) <b>702 Beaumont Ave</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>m</b>	8. DATE OF BIRTH <b>12-18-09</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>
13. FATHER'S NAME <b>ALFRED Woolley</b>			14. MOTHER'S MAIDEN NAME <b>Louise Wagner</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-7746</b>		17. INFORMANT ADDRESS <b>Mrs. Ruth G. Woolley Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>3-8-51</b>		CAUSE OF DEATH (A) <b>STATUS POST CHOLECYSTECTOMY</b> DUE TO (B) <b>RECENT</b> DUE TO (C) <b>ABSENCE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>ABSENCE</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Acute Cholecystitis</b>					
19A. DATE OF OPERATION <b>6-22-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cholecystitis. Deep distress</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. AGENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-21-1967</b> to <b>7-1-1967</b> , that (I) (we) last saw the deceased alive on <b>7-1-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hong Chul Yoon</b> M.D.				23B. DATE SIGNED <b>7-1-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR HONG C YOON</b>		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-3-67</b>	24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>		24D. LOCATION <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, Md. 21212</b>	

2-22-4

5-1-4

William John Jones



City  
2nd BEARMENT Ave  
12-18-42

Chas Memorial Hosp

M W M

Beaumont, and American  
Course Worker

ALFRED W. WELLS

RECENT  
STATUS POST CHOLECYSTECTOMY

*[Signature]*

6-22-42 Chas. Memorial Hosp  
Beaumont, Cal.

5-1-4 6-21-42 5-1-4

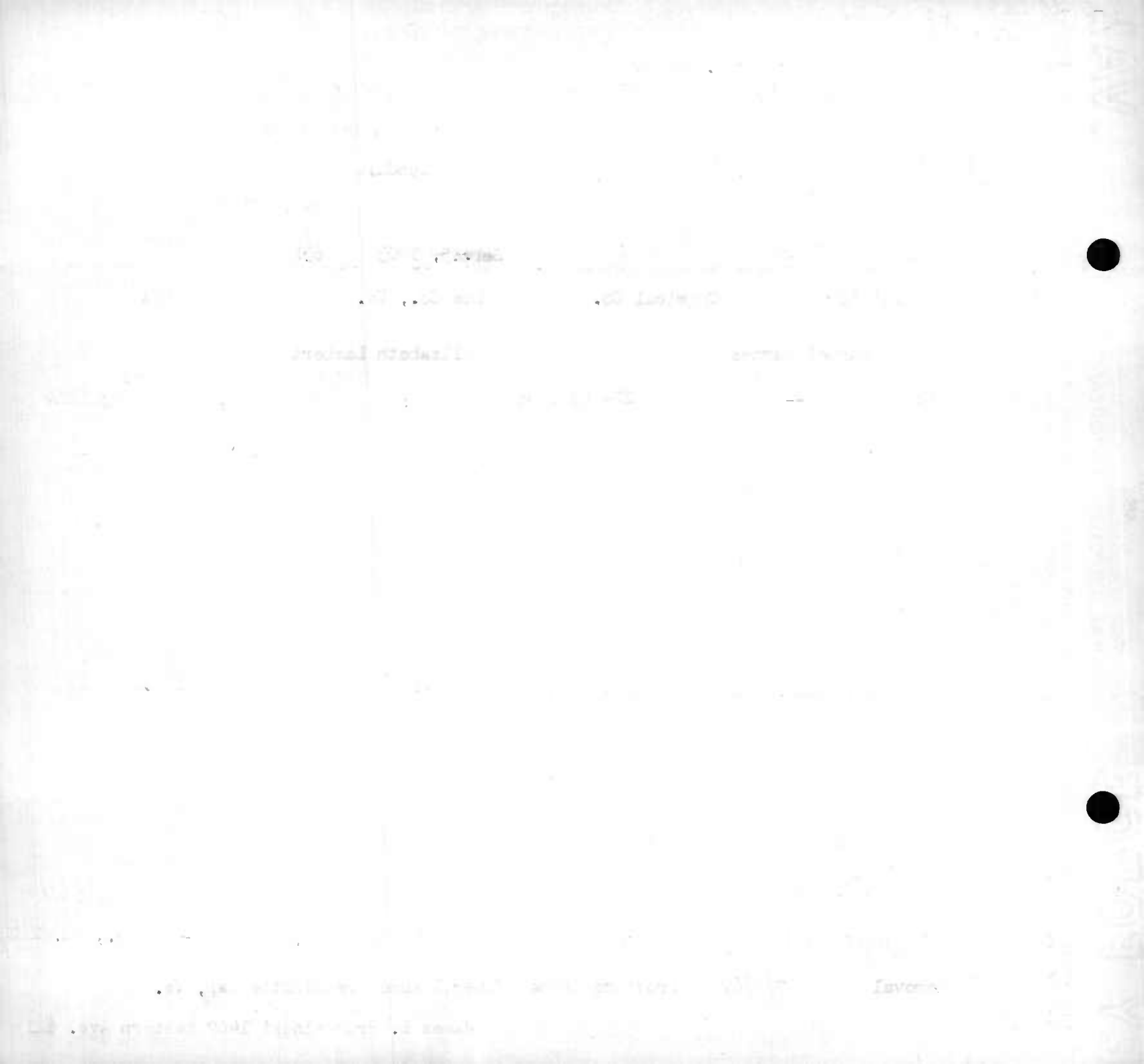
Chas. Memorial

2nd BEARMENT Ave

BIRTH NO.		67 6389		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6389	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Arthur L. Haynes</b>			
2. DATE AND HOUR OF DEATH <b>7/1/67 9:44 p.m.</b>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>Baltimore City Hospital</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland, Baltimore</b> B. COUNTY <b>Balto</b>				5. SEX <b>Male</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Dundalk</b>				6. RACE <b>White</b>			
D. STREET ADDRESS (If rural, give location) <b>2016 Wareham Road #21222</b>				7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4940 Eastern Avenue Baltimore, Maryland #21224</b>				8. DATE OF BIRTH <b>Sept. 5, 1903</b>			
9. AGE (In years lost birthday) <b>63</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>			
11. BIRTHPLACE (State or foreign country) <b>Lee Co., Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Samuel Haynes</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Lambert</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>224 03 2095</b>			
17. INFORMANT <b>BC# 4940 Eastern Avenue Baltimore, Maryland #21224</b>				18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>months</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b> years				20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>none</b>			
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>			
20A. AUTOPSY? (Yes or No) <b>NO</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1967</b> to <b>July 1, 1967</b> , that (I) (we) lost saw the deceased alive on <b>July 1, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>E. M. Levinsohn</b>				23B. DATE SIGNED <b>July 1, 1967</b>			
23C. PHYSICIAN'S NAME (Type) <b>Eugene M. Levinsohn</b>				23D. ADDRESS <b>BC# 4940 Eastern Avenue - Balto., Md. #21224</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				24B. DATE <b>7/2/67</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Province &amp; Thomas Funeral Home</b>				24D. LOCATION (City, town, or county) (State) <b>Pennington Gap, Va.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>				25B. NAME OF REGISTRAR <b>James E. Bruzdinski</b>			
25C. FUNERAL DIRECTOR <b>James E. Bruzdinski</b>				25D. ADDRESS <b>1407 Eastern Ave. #21</b>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





4-2351  
\* Signed for Burial by who is on  
FUNERAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		67 6390 LILLIAN WUESTNER		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6390	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson D. STREET ADDRESS (If rural, give location) 32 Acorn Circle			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1/23/1904	9. AGE (In years last birthday) 63	10. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME John Dekowski			14. MOTHER'S MAIDEN NAME Mary Purulewski				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 215-18-3668		17. INFORMANT Mrs. Christine Krausz, 6225 Tramore Rd.			
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. -				CAUSE OF DEATH (A) Hypertensive Cardiovascular Disease (B) Acute Pulmonary edema (C)  INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White <input type="checkbox"/> At Work Not White <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Donald W. Mintzer				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 3/1967	
23C. PHYSICIAN'S NAME (Type) DONALD W. MINTZER				23D. ADDRESS 3009 EVERGREEN AVE BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/67		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE			



BIRTH NO.

67 6391

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6391

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RONALD LEE CARROLL

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1967

4:48 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

John Hopkins Hospital

(DOA)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

531 South Ann Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Never Married

8. DATE OF BIRTH

July 27 1961

9. AGE (In years  
last birthday)

5

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Welch West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Harmey Lee Carroll

14. MOTHER'S MAIDEN NAME

Bonnie Sue Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Harmey Lee Carroll 531 South Ann Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple traumatic injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

steps

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

In front of 531 South Ann Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
6-30-67 4:40 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject struck  
by auto while sitting on steps

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 1, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

July 6, 1967

23C. NAME of CEMETERY or CREMATORY

Justus Cemetery

23D. LOCATION

(City, town, or county)

Davy

West Virginia

24A. DATE REC'D BY HEALTH DEPT.

JUL 5 1967

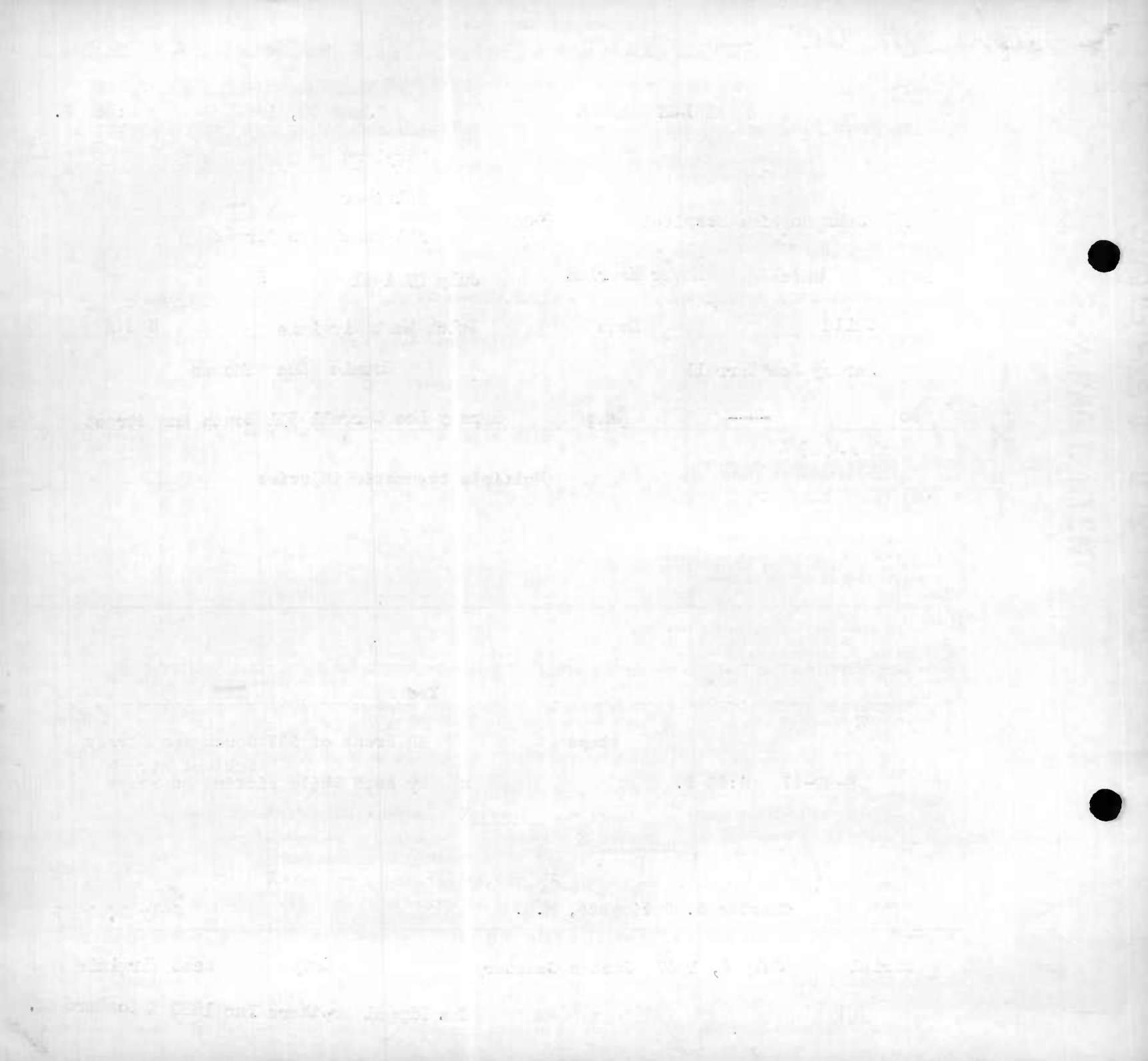
24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

ADDRESS

The Dippel Brothers Inc 1800 E Lombard St.



**B-362** **67 6392** **BALTIMORE CITY HEALTH DEPARTMENT** **67 6392**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. **67 6392**

**BIRTH NO.** **67 6392**

**M.E. CASE NO.**

**1. NAME OF DECEASED** (Type or Print) **GEORGE A. BOWDERS**

**2. DATE AND HOUR PRONOUNCED DEAD** **July 1, 1967** **10:15 A.**

**3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD**

**4. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)

**A. STATE** **Maryland** **B. COUNTY** **19-03**

**C. CITY OR TOWN** (If outside corporate limits, write RURAL and give township) **Baltimore**

**D. STREET ADDRESS** (If rural, give location) **25 S. Stricker Street**

**5. SEX** **Male** **6. RACE** **White** **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)** **married** **8. DATE OF BIRTH** **2/28/97** **9. AGE** (In years last birthday) **70** **If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.**

**10A. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) **Carpenter** **10B. KIND OF BUSINESS OR INDUSTRY** **Building** **11. BIRTHPLACE** (State or foreign country) **Penn.** **12. CITIZEN OF WHAT COUNTRY?** **U.S.A.**

**13. FATHER'S NAME** **Lewis Bowders** **14. MOTHER'S MAIDEN NAME** **Unknown**

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no or unknown) (If yes, give war or dates of service) **Yes** **U.W.I.** **16. SOCIAL SECURITY NO.** **216-12-5302** **17. INFORMANT** **Nellie Bowders** **ADDRESS** **25 S. Stricker St**

**18. CAUSE OF DEATH**

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) **(A) Arteriosclerotic cardiovascular disease**

**ANTECEDENT CAUSES** **DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.** **(B) DUE TO** **(C)**

**II**

**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.**

**19A. DATE OF OPERATION** **0** **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** **20A. AUTOPSY? (Yes or No)** **No** **20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?**

**21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.** **21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

**21D. TIME OF INJURY (APPROX.)** (Month) (Day) (Year) (Hour) **21E. INJURY OCCURRED** **WHILE AT WORK** **NOT WHILE AT WORK** **21F. HOW DID INJURY OCCUR?**

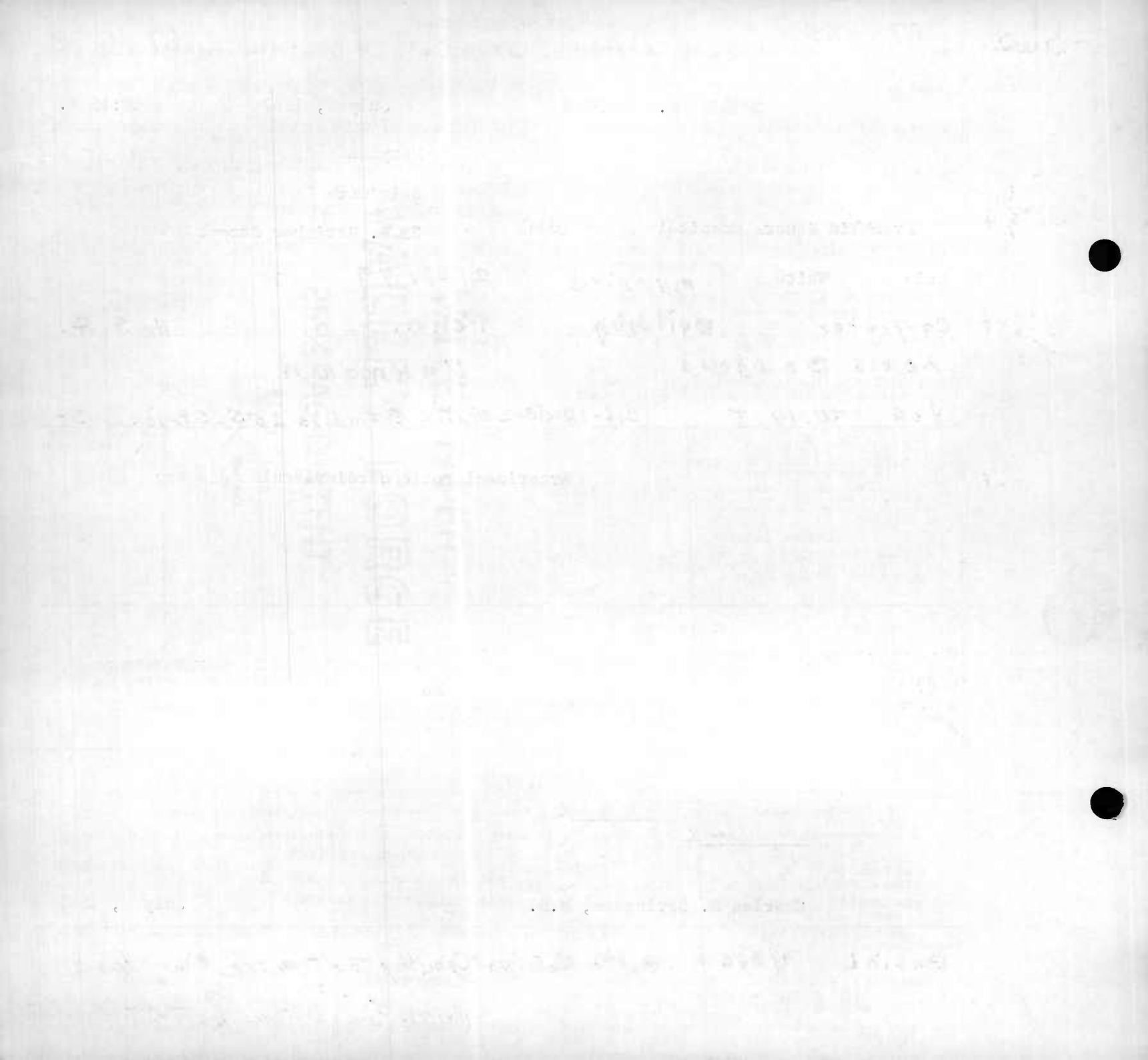
**22. I certify that I held an Inquiry** **Inspection** **Autopsy** **and that on this basis, death in my opinion resulted from:** **Natural causes** **Accident** **Suicide** **Homicide** **Undetermined manner**

**ACTUAL SIGNATURE** **Charles S. Springate, M.D.** **CHIEF MEDICAL EXAMINER** **DATE SIGNED** **July 2, 1967**

**EXAMINER'S NAME (Type)** **Charles S. Springate, M.D.** **ASSISTANT MEDICAL EXAMINER** **ASSOCIATE MEDICAL EXAMINER**

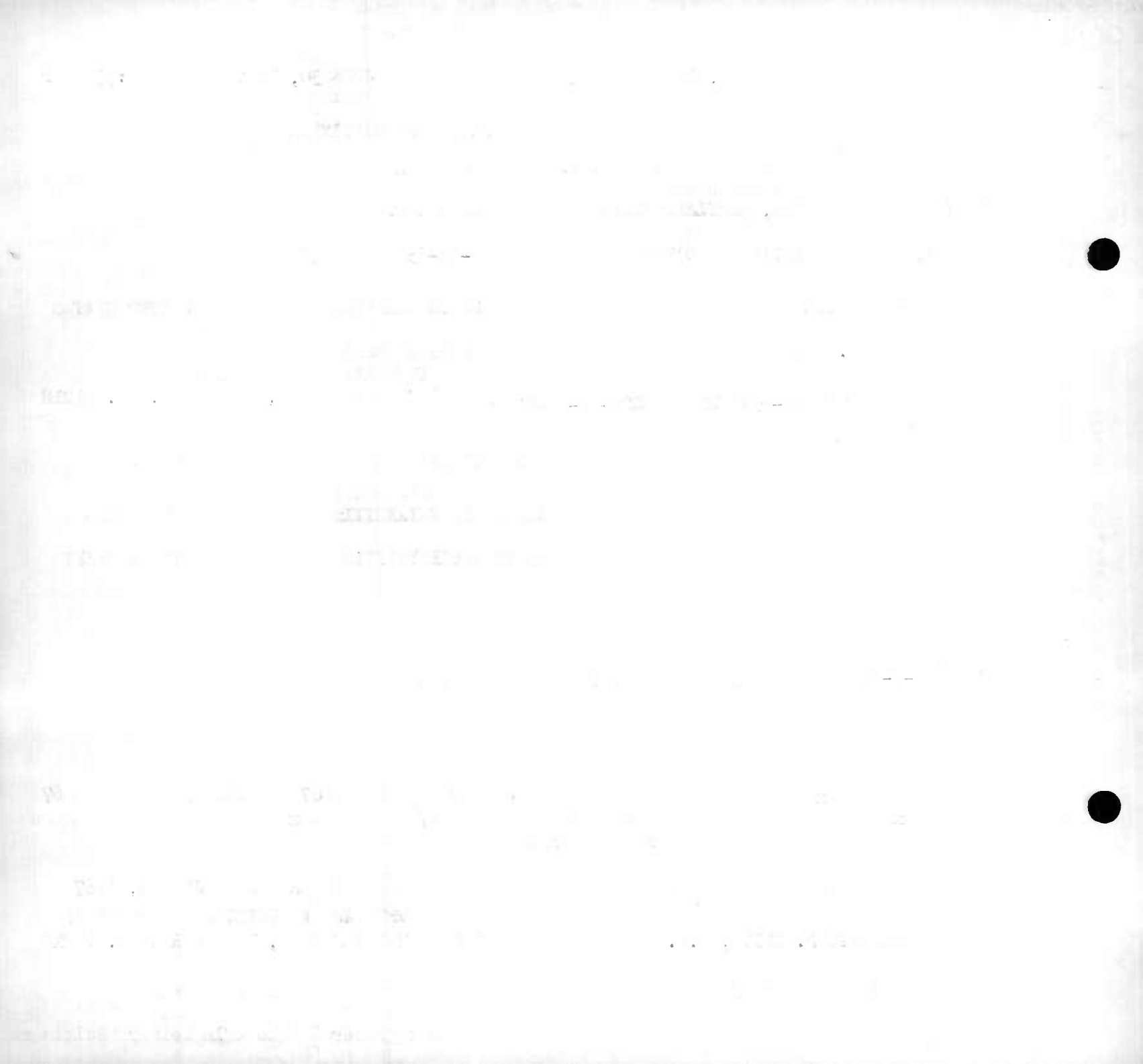
**23A. BURIAL CREMATION, REMOVAL (Specify)** **Burial** **23B. DATE** **7/5/67** **23C. NAME of CEMETERY or CREMATORY** **Balto. National Cemetery** **23D. LOCATION** (City, town, or county) (State) **Baltimore, Maryland**

**24A. DATE REC'D BY HEALTH DEPT.** **JUL 5 1967** **24B. NAME OF REGISTRAR** **Robert E. Finkbeiner** **24C. FUNERAL DIRECTOR** **Walter Funeral Home** **ADDRESS** **Pratt + Stricker St.**



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6393	
1. NAME OF DECEASED (Type or Print)		MAXWELL, CONDOR BERT		2. DATE AND HOUR OF DEATH JUNE 30, 1967 10:55 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		MARYLAND BALTIMORE 25-05			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		4100 CURTIS AVENUE			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 8-24-93	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
BAGGAGE MASTER				NORTH CAROLINA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
WILLIAM B. MAXWELL		NAVY SESSOMS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMATION FROM VETERANS HOSPITAL RECORDS ADDRESS	
YES 7/9/18-9/30/21		204-03-99-23		3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		ONE WEEK	
ANTECEDENT CAUSES		(B) DUE TO		TWO WEEKS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		THREE WEEKS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
6-9-67		ACUTE CHOLECYSTITIS		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from JUNE 9 1967 to JUNE 30 1967, that (we) last saw the deceased alive on JUNE 30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Ernesto P. Smith</i>				JULY 1, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ERNESTO P. SMITH, M.D.				VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
removal		July 1/67		Fisher Cemetery Cumberland Co North Carolina	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 5 1967		<i>Robert E. Fisher</i>		Ullrich Funeral Home 4210 Belair Baltimore	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6394</b>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <b>67 6394</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Maude M Rosenthal</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>June 27/67 7.55pm</b>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3113 Ravenwood Ave</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>8-01</b>  <b>5. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>Baltimore</b>  <b>6. STREET ADDRESS</b> (If rural, give location) <b>3113 Ravenwood Ave</b>		
<b>5. SEX</b> <b>female</b>	<b>6. RACE</b> <b>white</b>	<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>widow</b>	<b>8. DATE OF BIRTH</b> <b>May 26 1896</b>	<b>9. AGE</b> (In years lost birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>at home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Penn</b>	
<b>13. FATHER'S NAME</b> <b>Edward McAflin</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary M Dunn</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT ADDRESS</b> <b>Lewis A Brown 2903 Old Joppa Road</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b>  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b>  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>CAUSE OF DEATH</b> (A) <b>Heart Block - strokes came from 11/20/65</b> DUE TO (B) <b>Coronary Sclerosis</b> 2 yrs. DUE TO (C) <b>Arteriosclerotic C.V.D.</b> 4 yrs. <b>Hypertensive C.V.D.</b> 6 yrs.		
			<b>INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 11/20 1965 to 6/27 1967 that (I) (we) last saw the deceased alive on 4/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Isadore Grossman</b> M.D.				<b>23B. DATE SIGNED</b> <b>6/30/67</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type)				<b>23D. ADDRESS</b>	
<b>Isadore Grossman</b> M.D.				<b>1527 E North Ave Baltimore</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)		<b>24B. DATE</b>		<b>24C. NAME of CEMETERY or CREMATORY</b>	
<b>Burial</b>		<b>June 29/67</b>		<b>Holy Redeemer Cemetery</b>	
				<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JUL 5 1967</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Farley</b>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> <b>Ullrich Funeral Home 4210 Belair Road</b>	



BIRTH NO.

67 6395

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6395

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT MARCUS

2. DATE AND HOUR PRONOUNCED DEAD

July 2, 1967

8:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

540 Wilson Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

5-26-36

9. AGE (In years  
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Willie Marcus

14. MOTHER'S MAIDEN NAME

Ophelia

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Evelyn Marcus 4720 Williston

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Gunshot wound of neck  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

540 Wilson Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
7-1-67 4:15 A.M.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot by unknown assailant

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 2, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-6-67

23C. NAME of CEMETERY or CREMATORY

Church Cemetery

23D. LOCATION

(City, town, or county)

(State)

Lamar, South Carolina

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 5 1967 Robert E. Farley, M.D.

Kelson Funeral Home 1348 Calhoun St.



M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **ELSIE J. Pendergast** 2. DATE AND HOUR PRONOUNCED DEAD **July 1, 1967 5:10 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland** B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**1616 Clifton Avenue** **Baltimore**

D. STREET ADDRESS (If rural, give location) **1616 Clifton Avenue**

5. SEX **Female** 6. RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Divorced** 8. DATE OF BIRTH **7-15-33** 9. AGE (In years last birthday) **33** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Gilbert Hayes** 14. MOTHER'S MAIDEN NAME **Annie**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS **Annie Hayes 1616 Clifton Avenue**

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) **Carcinoma of uterine cervix with widespread metastases**

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Springate** M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **July 2, 1967**  
EXAMINER'S NAME (Type) **Charles S. Springate, M.D.**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **7-5-67** 23C. NAME of CEMETERY or CREMATORY **Mt. Auburn Cem** 23D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

24A. DATE REC'D BY HEALTH DEPT. **JUL 5 1967** 24B. NAME OF REGISTRAR **Robert E. Farley, M.D.** 24C. FUNERAL DIRECTOR ADDRESS **Kelson Funeral Home 1348 Calhoun St.**

VALLEY PAPER

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WALLLEY FORDS

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C-514

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 6397		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6397	
M.E. CASE NO.		2. DATE AND HOUR PRONOUNCED DEAD July 1, 1967 1:52 A.M.	
1. NAME OF DECEASED (Type or Print) RALPH W. CAMPBELL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 839 N. Augusta Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 839 N. Augusta Avenue	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH April 28, 1908
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 59
11. BIRTHPLACE (State or foreign country) Essex Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willie Campbell		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes II		16. SOCIAL SECURITY NO. 225-26-6744	
17. INFORMANT Grace Jeffries, 839 N Augusta Ave.		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED July 1, 1967			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7-5-67	
23C. NAME OF CEMETERY or CREMATORY Baltimore National		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT. JUL 5 1967		24B. NAME OF REGISTRAR Charles R. Law, 802 Madison Ave.	
24C. FUNERAL DIRECTOR		ADDRESS	

WILLIAMSON COUNTY, TENNESSEE  
APRIL 1901

WILLIAMSON COUNTY, TENNESSEE  
APRIL 1901  
WILLIAMSON COUNTY, TENNESSEE  
APRIL 1901  
WILLIAMSON COUNTY, TENNESSEE  
APRIL 1901

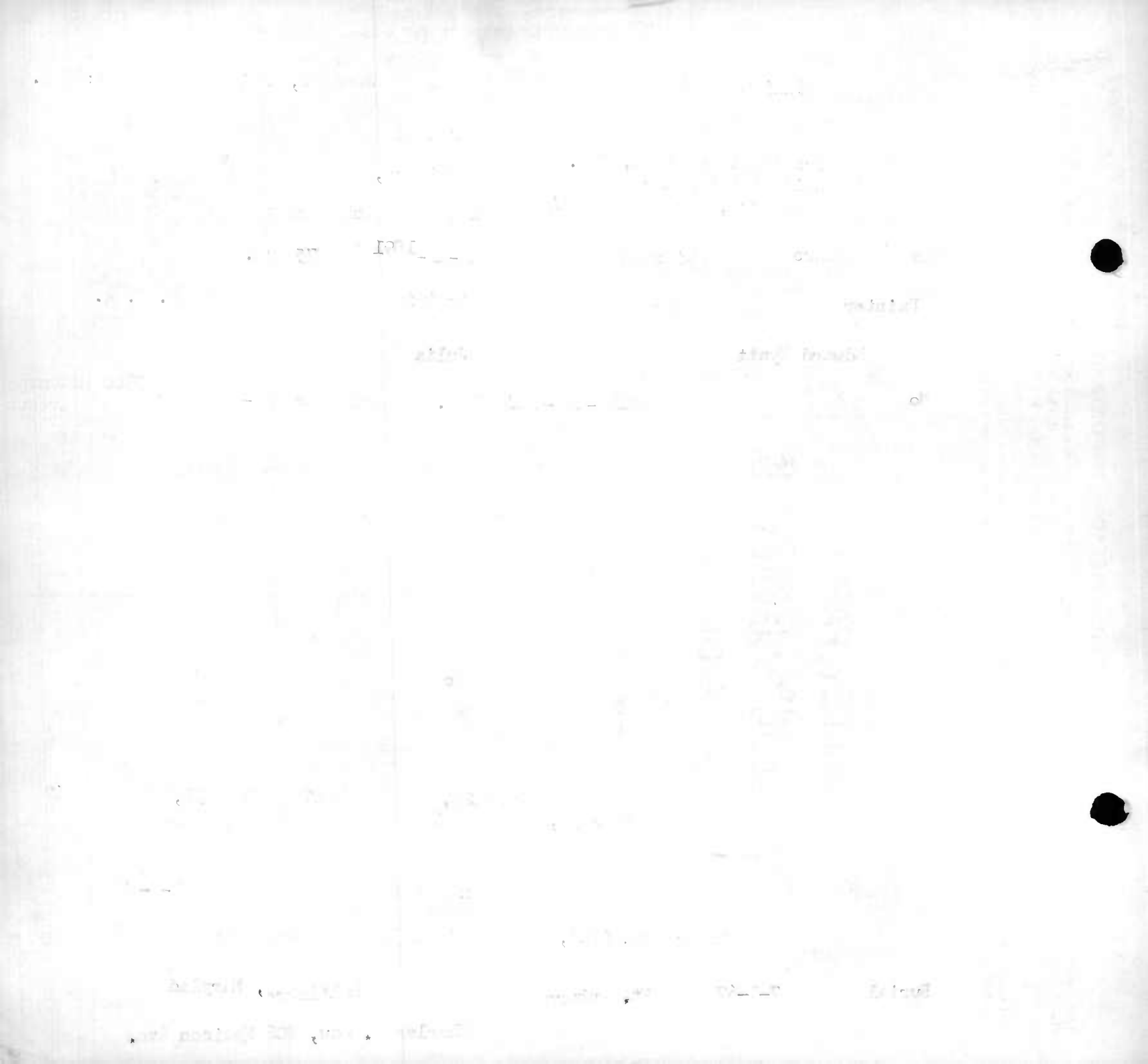
WILLIAMSON COUNTY, TENNESSEE  
APRIL 1901  
WILLIAMSON COUNTY, TENNESSEE  
APRIL 1901  
WILLIAMSON COUNTY, TENNESSEE  
APRIL 1901



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6398				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6398	
1. NAME OF DECEASED (Type or Print) <b>William Wyatt</b>				2. DATE AND HOUR OF DEATH <b>June 30, 1967 5:25 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1612 McCulloh Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>11-12-1892</b>	9. AGE (In years last birthday) <b>75 yrs.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Wyatt</b>				14. MOTHER'S MAIDEN NAME <b>Julia</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212 -16 -5917</b>		17. INFORMANT <b>Mrs. Catherine Greene-daughter</b>		ADDRESS <b>3900 Bateman Avenue</b>	
18. <b>442X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>CARDIO-VASCULAR RENAL DISEASE</b> DUE TO (B) <b>ARTERIOSCLEROSIS (GENERALIZED)</b> DUE TO (C) <b>SENILITY</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 23, 1967</b> to <b>June 30, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 30, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Gilbert L. Banfield</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>7-3-67</b>			
23C. PHYSICIAN'S NAME (Type) <b>Gilbert Banfield, M.D.</b>				23D. ADDRESS <b>722 N. 7th (HON AVE, BALTIMORE MD)</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-3-67</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles R. Law, 802 Madison Ave.</b>			



BIRTH NO. 67 6399  
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **CHARLES MAYS**  
2. DATE AND HOUR PRONOUNCED DEAD **July 2, 1967** | **11:00 p.m.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland**  
B. COUNTY **5-04**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

D. STREET ADDRESS (If rural, give location)  
**2108 Mura Street**

5. SEX **Male** 6. RACE **Colored** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married** 8. DATE OF BIRTH **Dec. 1, 1913** 9. AGE (In years last birthday) **52** 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer Bullock's Steel Co.** 11. BIRTHPLACE (State or foreign country) **Greenville N.C.** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Charles Mays** 14. MOTHER'S MAIDEN NAME **Addie** 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. 17. INFORMANT **Annie R Mays** ADDRESS **1225 Curley St**

18. CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) **Acute coronary occlusion with fresh myocardial infarction**  
(B) **fresh myocardial infarction**  
(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **YES** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **YES**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE **Russell S. Fisher, M.D.** M.D. DATE SIGNED **July 3, 1967**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **July 7/67** 23C. NAME OF CEMETERY or CREMATORY **Arbutus Memorial Park** 23D. LOCATION (City, town, or county) (State) **Arbutus Md.**

24A. DATE REC'D BY HEALTH DEPT. **JUL 5 1967** 24B. NAME OF REGISTRAR **Paul E. Fisher, M.D.** 24C. FUNERAL DIRECTOR **Milton E. Elchman** ADDRESS **1129 N. Caroline St**

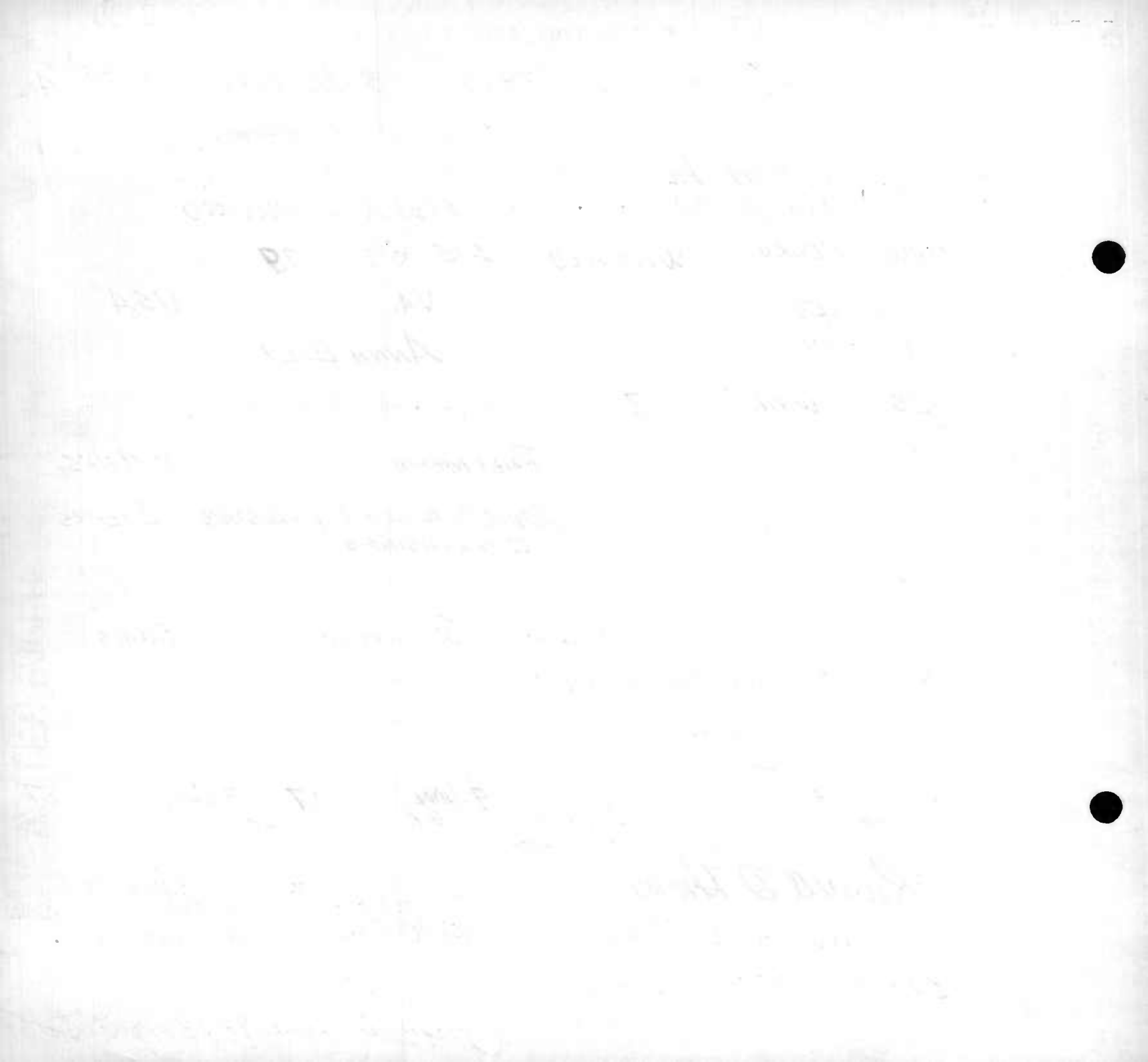
VS 151-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6400		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6400	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JONES, PERCELL (PERCY)		2. DATE AND HOUR OF DEATH 3 JULY 1967 1:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-04	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Md. 21224		D. STREET ADDRESS (If rural, give location) 2131 N SMALLWOOD ST			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2-15-89	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME ANNA ELEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) YES LINKN.		16. SOCIAL SECURITY NO. ?		17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA		CAUSE OF DEATH (A) DUE TO PNEUMONIA (B) DUE TO ADENOCARCINOMA of PROSTATE & METASTASIS (C)		INTERVAL BETWEEN ONSET AND DEATH 24 HRS. 2 YEARS	
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. FRACTURE of (R) HUMERUS				8 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/25/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ADENOCARCINOMA of PROSTATE		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from 19 JUNE 19 67 to 3 JULY 19 67, that (I) (we) last saw the deceased alive on 2 JULY 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Russell D Hicks		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3 JULY 1967	
23C. PHYSICIAN'S NAME (Type) RUSSELL D. HICKS		23D. ADDRESS Baltimore City Hospitals 4940 EASTERN AVE. Baltimore, Md.		21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/7/67		24C. NAME of CEMETERY or CREMATORY CARVER MEM. PK	
24D. LOCATION (City, town, or county) (State) LAUREL Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Joseph G. Locks		25D. ADDRESS 1304 N. Central Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/85





1  
D-552

67 6402

BALTIMORE CITY HEALTH DEPARTMENT

67 6402

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LEVIN DOWNING

2. DATE AND HOUR PRONOUNCED DEAD

July 1, 1967

6:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

4/4 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

327 East 23rd Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Dec 6, 1947

9. AGE (In years  
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

LEVIN DOWNING

14. MOTHER'S MAIDEN NAME

SARAH SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

SARAH SMITH 327 E. 23rd St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebrocranial injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

school playground

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

2000 Cecil Avenue

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
6-29-67 8:15 P.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Struck by baseball bat during alterca-  
tion.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 1, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-5-67

23C. NAME of CEMETERY or CREMATORY

Mt. CALVARY

23D. LOCATION

(City, town, or county)

A.A. County, Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 5 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Joseph B. Locks Jr. 1304 N. Central

ADDRESS

WILLIAM FORGE

WILLIAM FORGE

WILLIAM FORGE

WILLIAM FORGE

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1  
N. 220

67 6403

BALTIMORE CITY HEALTH DEPARTMENT

67 6403

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Caroline CAROLYN NOWAKOWSKI

2. DATE AND HOUR PRONOUNCED DEAD

July 2, 1967

6:35 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

JOHNS HOPKINS HOSPITAL D.O.A.

202 North Luzerne Avenue

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
lost birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

Female

White

Widowed

Nov. 24, 1899

67

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. J. Nowakowski 3450 McShane Way

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular  
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-6-67

23C. NAME of CEMETERY or CREMATORY

Oaklawn Cemetery

23D. LOCATION

Baltimore Md.

July 3, 1967

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 5 1967

Robert E. Fisher, M.D.

B. Dabrowski 2818 E. Baltimore St.

VALLEY PRODUCE

WHITE PAPER

2-7-1940

Addressed to the  
Director

1  
S-530

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 6404		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6404	
M.E. CASE NO.		2. DATE AND HOUR PRONOUNCED DEAD	
1. NAME OF DECEASED (Type or Print) <b>JOHN WEST SMITH</b>		July 2, 1967 6:55 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-06</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL D.O.A.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2916 West North Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>2-29-1948</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>	9. AGE (In years last birthday) <b>19</b>
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLARENCE BELTON</b>		14. MOTHER'S MAIDEN NAME <b>ALMETER SMITH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs. Almeter Diggs 2916 W. North Av</b>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Rheumatic Heart Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>July 3, 1967</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>7-7-67</b>	
23C. NAME OF CEMETERY or CREMATORY <b>Mount Auburn Cem.</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
24C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		24D. ADDRESS <b>1701 Laurens St.</b>	

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10/1/01 BY 60322  
UC/LP/P/DRG/E

U.S. DEPARTMENT OF JUSTICE

RECORDS SECTION

U.S. DEPARTMENT OF JUSTICE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HERMAN CANNIE GARDNER (Hermon)

2. DATE AND HOUR PRONOUNCED DEAD

July 2, 1967 2:45 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2561 Edmondson Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2561 Edmondson Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

7-14-1924

9. AGE (in years  
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

RALEIGH, NORTH CAROLINA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIE GARDNER

14. MOTHER'S MAIDEN NAME

PROVANE GARDNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

241-30-8538 Mrs. Annie Gardner 2561 Edmondson Ave.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular  
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 3, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-7-67

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat'l Cem.

23D. LOCATION

(City, town, or county) (State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 5 1967

R. E. Fisher, M.D.

MORTON &amp; Dyett F.H. 1701 Laurens Str.

NO. 100-100000



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

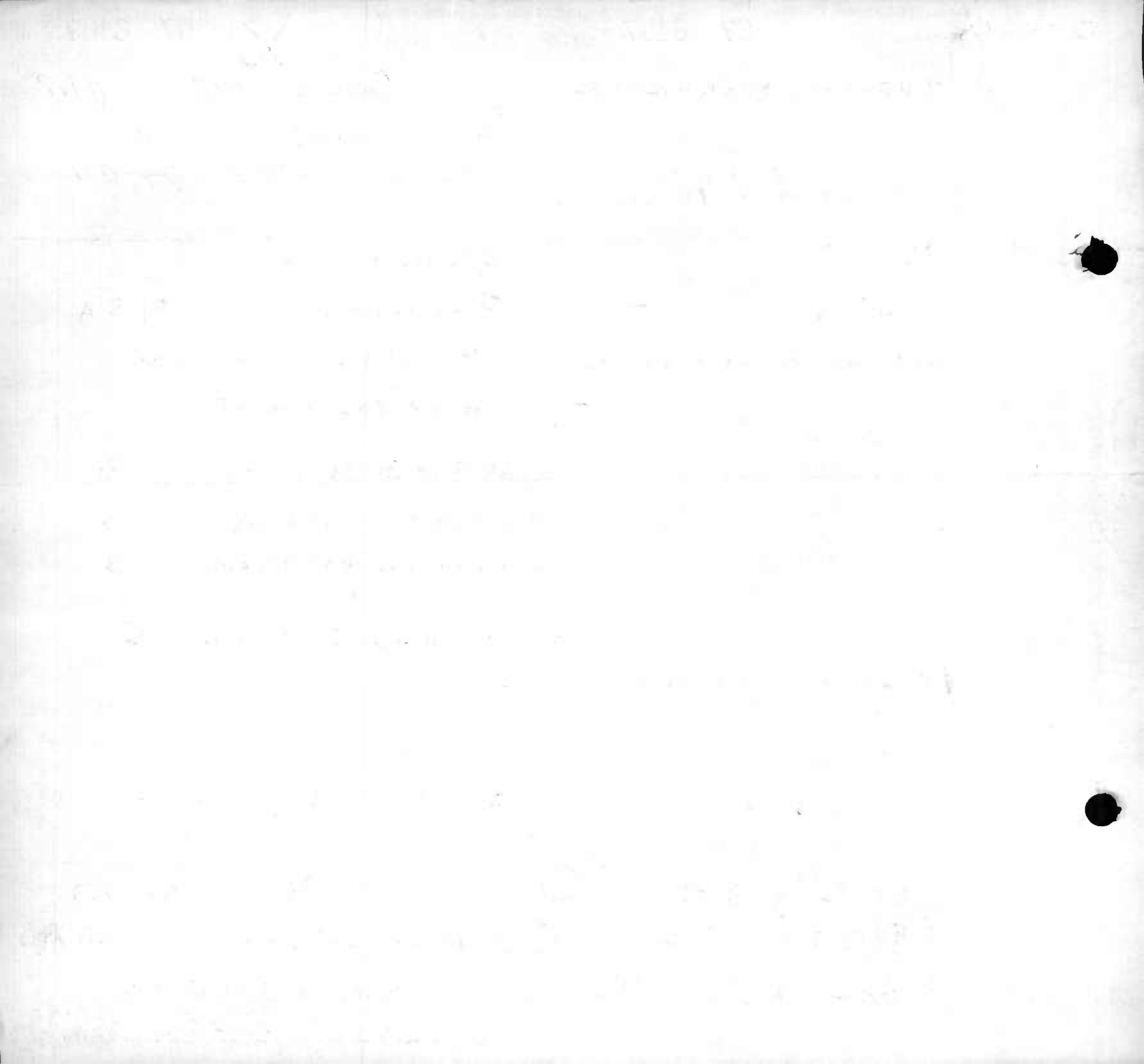
BALTIMORE CITY HEALTH DEPARTMENT										
67 6406					67 6406					
BIRTH NO.					REGISTERED NO.					
1. NAME OF DECEASED (Type or Print) <b>Sharon Sue Sarll</b>					2. DATE AND HOUR OF DEATH <b>June 30, 1967</b>   <b>12:35 P M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital 3100 Wyman Pk. Drive</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ohio</b> B. COUNTY <b>1-32</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Barberton</b> D. STREET ADDRESS (If rural, give location) <b>315 Norton Ave.</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>7/21/47</b>	9. AGE (In years lost birthday) <b>19</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Private INC.</b>		11. BIRTHPLACE (State or foreign country) <b>Ind. , Walbask</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Glenn Sarll</b>					14. MOTHER'S MAIDEN NAME <b>Florence Hostinsky</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>303-52-5652</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>					
18. <b>193.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Neuroblastoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>			
19A. DATE OF OPERATION <b>2</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 8</b> 19 <b>67</b> to <b>June 30</b> 19 <b>67</b> . that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 30</b> 19 <b>67</b> and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>Michael E. Pelczar</b> M.D.					23B. DATE SIGNED <b>6/30/67</b>			23C. PHYSICIAN'S NAME (Type) <b>Michael E. Pelczar, SA Surgeon (R)</b> M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>					24B. DATE <b>7/5/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY CROSS CEMETERY AKRON OHIO</b>		24D. LOCATION (City, town, or county) (State) <b>AKRON OHIO</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>			25B. NAME OF REGISTRAR <b>Robert E. Farber</b>			25C. FUNERAL DIRECTOR <b>James M. Fields - Baltimore md</b>			ADDRESS	

Michael S. P. P.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. <u>Washington Co. Md 67 6407</u>					CERTIFICATE OF DEATH					Registered No. <u>67 6407</u>				
1. NAME OF DECEASED <u>THE DORE BORK HOLDER</u>										2. DATE AND HOUR OF DEATH <u>June 30th 1967 11:10 P.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL BALTIMORE MARYLAND</u>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>WASHINGTON</u>				
5. SEX <u>M</u> 6. RACE <u>Can</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)										8. DATE OF BIRTH <u>6/25/64</u> 9. AGE (In years last birthday) <u>3</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>										10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>				
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>										12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>LIONEL BORK HOLDER</u>										14. MOTHER'S MAIDEN NAME <u>MARTHA LUTMAN</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO. <u>-</u>				
17. INFORMANT <u>HOSPITAL CHART</u>										ADDRESS				
18. <u>75451</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CYANOTIC HEART DISEASE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>TRICUSPID STENOSIS</u> <u>CONGENITAL HEART DISEASE</u>										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
19. DATE OF OPERATION <u>6/23/67</u>										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>TRICUSPID ATRESIA</u>				
20A. AUTOPSY? (Yes or No)										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>										21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>6-11-67</u> to <u>6-30-67</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										23A. SIGNATURE <u>Chris J. Beutel</u>				
23B. DATE SIGNED <u>6/30/67</u>										23C. PHYSICIAN'S NAME (Type) <u>CHRIS J. BEUTEL</u>				
23D. ADDRESS <u>UNIVERSITY HOSPITAL BALTIMORE</u>										24A. BURIAL CREMATION, REMOVAL (Specify)				
24B. DATE <u>JUL 3 1967</u>										24C. NAME OF CEMETERY or CREMATORY <u>PRICE'S CEMETERY WAYNESBORO PA.</u>				
24D. LOCATION (City, town, or county) (State) <u>CLEAR SPRING, MD.</u>										25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1967</u>				
25B. NAME OF REGISTRAR <u>Robert E. Farber</u>										25C. FUNERAL DIRECTOR <u>Donald E. Thompson</u>				



1  
P-623

67 6408

BALTIMORE CITY HEALTH DEPARTMENT

67 6408

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH L. PRESTI

2. DATE AND HOUR PRONOUNCED DEAD

July 1, 1967

6:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1502 Belt Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1502 Belt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10/28/02

9. AGE (In years  
last birthday)

63 64

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR INDUSTRY

had own shop

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Vincent Presti

14. MOTHER'S MAIDEN NAME

Angolina Miciche

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

216-32-8957

17. INFORMANT

ADDRESS

Dora K. Presti 1502 Belt St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 1, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7/5/67

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 5 1967

Charles E. Fairbank

Charles L. Stevens Funeral Home, Inc.  
1501 East Fort Avenue

WILKINSON

1864

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6409

BIRTH NO. 67 6409

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RONALD

E.

BOOTH

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1967

10:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Maryland Penitentiary

954 Forrest Street

Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1506 Boyle Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

1/8/36

9. AGE (In years  
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Bureau of Sanitation Balto. City

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Charles H. Booth

14. MOTHER'S MAIDEN NAME

Sylvia Peterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Sylvia Brokos 1518 Covington St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Hanging  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Jail Cell

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

954 Forrest Street

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

June 29, '67 UNK

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Subj used strips of  
bed sheets and hung himself

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/30/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7/3/67

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 5 1967

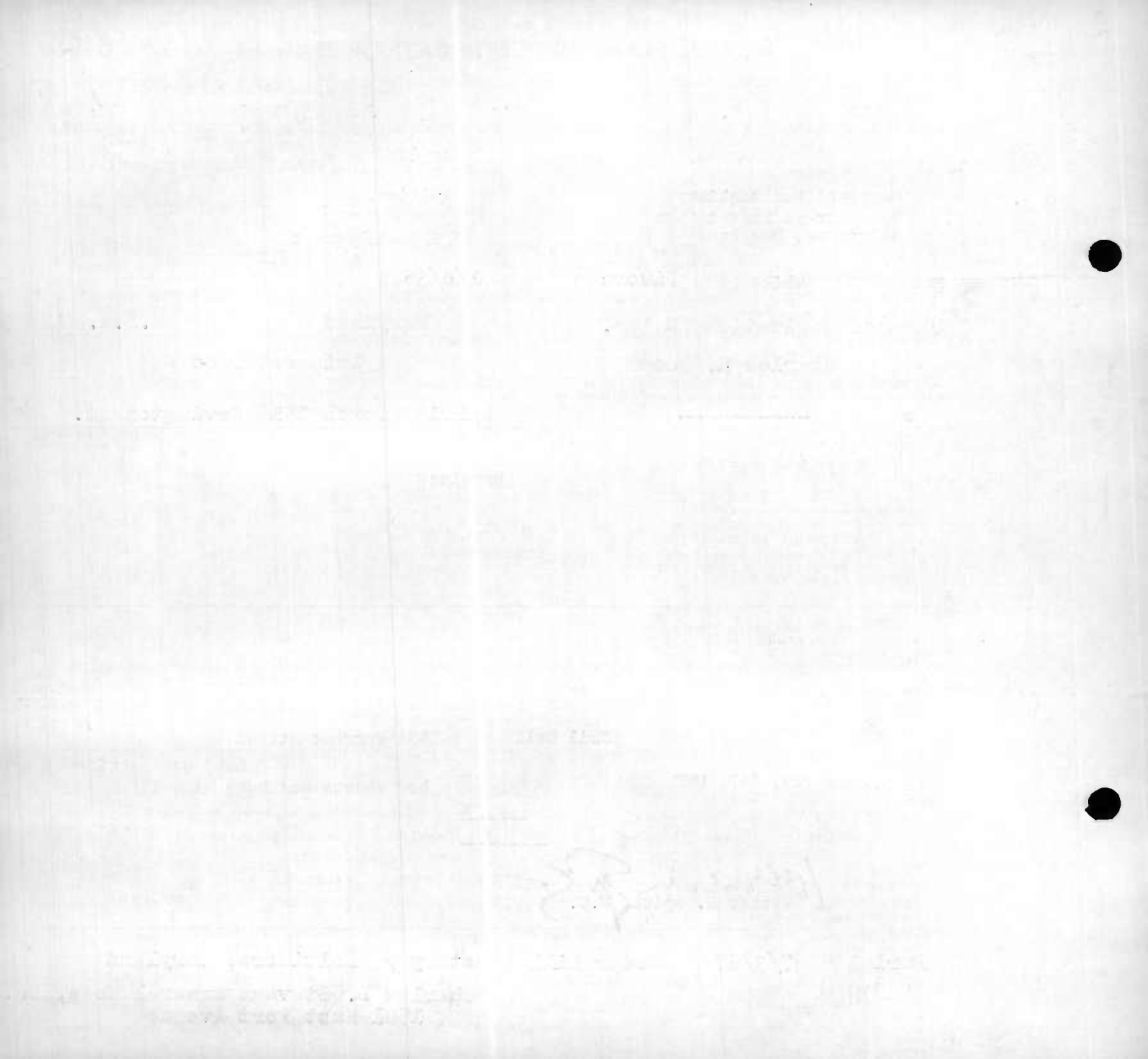
24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Charles L. Stevens Funeral Home, Inc.

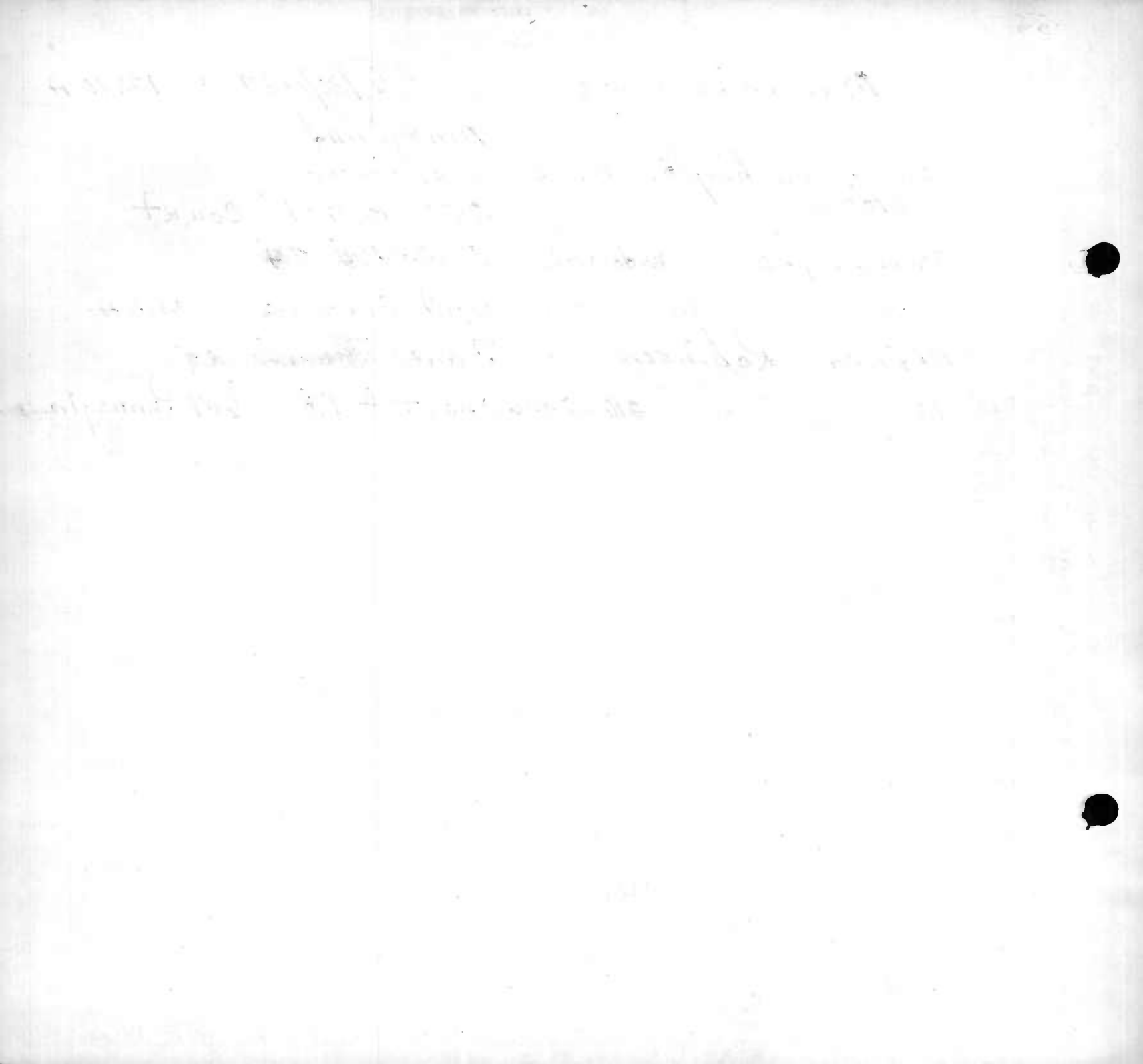
1501 East Fort Avenue





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6410</b>	
BIRTH NO. <b>67 6410</b>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Mabel R. Jennings</b>		2. DATE AND HOUR OF DEATH <b>6/30/1967 12:10 A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>George Washington NURS. Home</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>X</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 6-05</b>			
		D. STREET ADDRESS (If rural, give location) <b>252 Bethel Court</b>			
5. SEX <b>Female</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>5-12-1894</b>	9. AGE (In years last birthday) <b>73</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PRIVATE FAMILY</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>ALFRED Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Jane MARIA BROWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-18-0856</b>		17. INFORMANT <b>Chart # 778</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>181.0 I</b>		CAUSE OF DEATH (A) <b>Carcinoma of bladder</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>3 mth</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 29 1967</b> to <b>19</b> that (I) (we) lost saw the deceased alive on <b>June 29 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J-N. Mac MURPHY</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>J-N. MAC MURPHY</b>		23D. ADDRESS <b>2500 Garrison Blvd Baltimore 16 Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7/3/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>ARBUTUS MEMORIAL PK</b>	
24D. LOCATION (City, town, or county) (State) <b>ARBUTUS BALTO Co. MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>HERBERT E. NUTTER</b>	
				ADDRESS <b>3035 W. North Ave</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6411		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 67 6411	
1. NAME OF DECEASED (Type or Print) <b>HELEN C. MURRAY</b>			2. DATE AND HOUR OF DEATH <b>7-2-67 7:55A M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2810 AUCHENTEROLY TERRACE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4-28-93</b>	9. AGE (In years last birthday) <b>74</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher-Ret.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher-Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOHN CARTER</b>			14. MOTHER'S MAIDEN NAME <b>WILLIE PINKETT</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>George Lee Murray-2810 Auchenteroly Ter</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>331X I</b> <b>Suspected Gram-neg sepsis</b> <b>10 days</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>6/20</b> 19 <b>67</b> to <b>7/2</b> 19 <b>67</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>7/2</b> 19 <b>67</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Henry R. Black</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>7/2/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>HENRY BLACK</b>		23D. ADDRESS <b>Johns Hopkins Hospital</b> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/6/1967</b>	24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore County Maryland</b>		
25A. DATE RECEIVED BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter -3035 W. North Ave.</b>		



1  
5-536

67 6412

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6412

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WORTHY Cox SANDERS Sr.

2. DATE AND HOUR PRONOUNCED DEAD

July 4, 1967 8:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL ( DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)  
1720 E. 30th Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 30, 1924

9. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Bendex Radio

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Worthy W. Sanders

14. MOTHER'S MAIDEN NAME

Pearl Cox

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W.2

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Katherine Sanders

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Fayette and Washington Sts.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)  
7/4/67 7:30 A.

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

driver in auto-auto collision

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/4/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7/7/67

23C. NAME of CEMETERY or CREMATORY

Dulaney Valley Cem.

23D. LOCATION

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 5 1967

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. Md.

ADDRESS

WALLEY FORGE

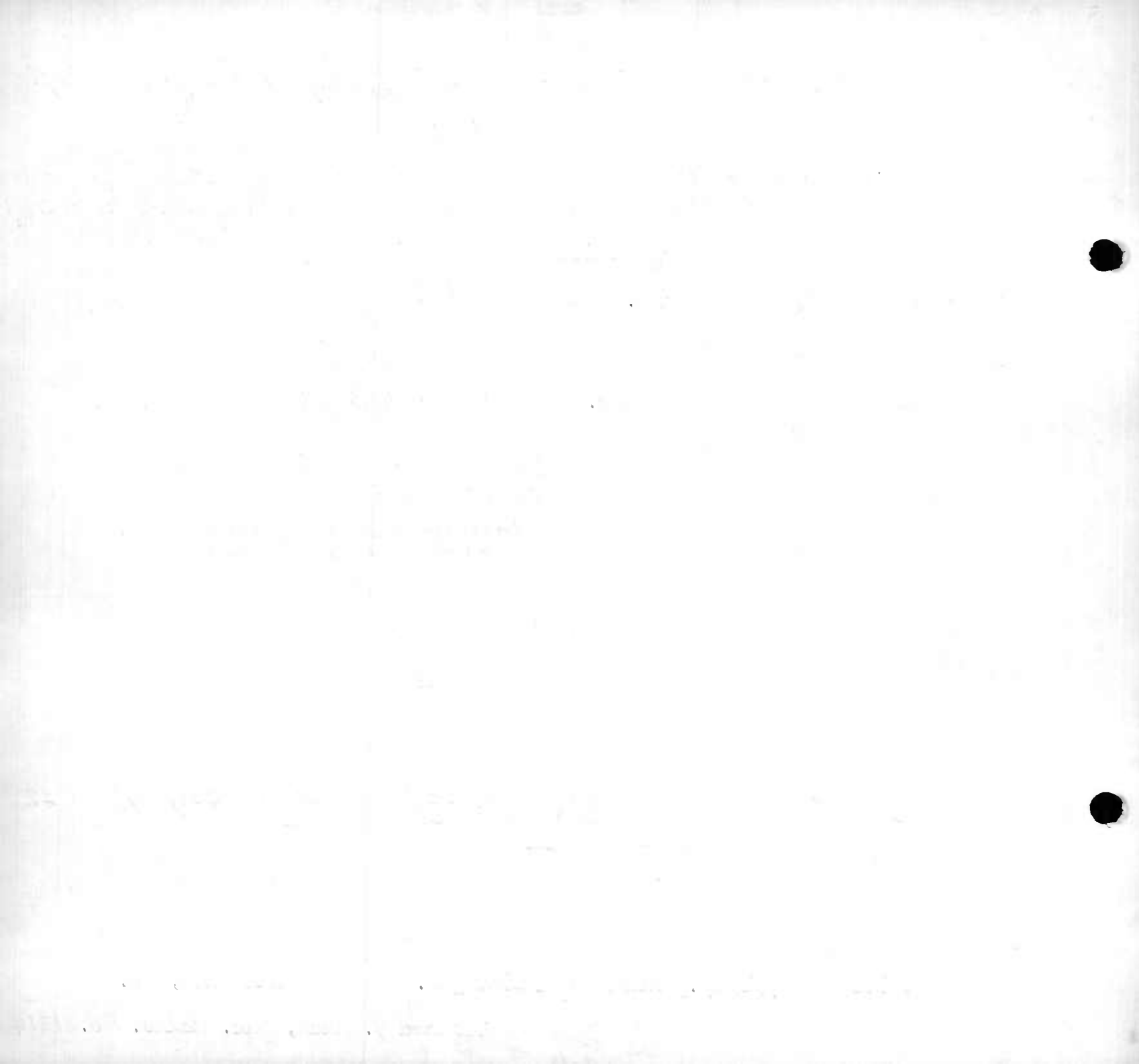
WALLEY PAPER



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 67 6413	
BIRTH NO. 67 6413		M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>BRYDGES BARBARA Ellen</b>				2. DATE AND HOUR OF DEATH <b>July 4<sup>th</sup> - 1967 5:30<sup>p</sup> M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b>				A. STATE <b>MD</b> B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 26-03</b>			
				D. STREET ADDRESS (If rural, give location) <b>1881 Freedom Way North, Balto 21213</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10/17/39</b>	9. AGE (In years last birthday) <b>27</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>office clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles L. CHAPMAN</b>				14. MOTHER'S MAIDEN NAME <b>Emma I. Christian</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Robert D. Brydges, husband.</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>CHD - Interatrial septal defect - PULMONARY REGURGITATION</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>MASSIVE CEREBRAL INFARCTION etiology undetermined -</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Repair of ASD</b>							
19A. DATE OF OPERATION <b>3 June 1967</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ASD</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>6/25/1967</b> to <b>July 4, 1967</b> , that (we) last saw the deceased alive on <b>July 4, 1967</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>R. Sanford, M.D.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4 July 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Univ. Hosp.</b>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/8/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE RECD BY HEALTH DEPT. <b>JUL 5 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

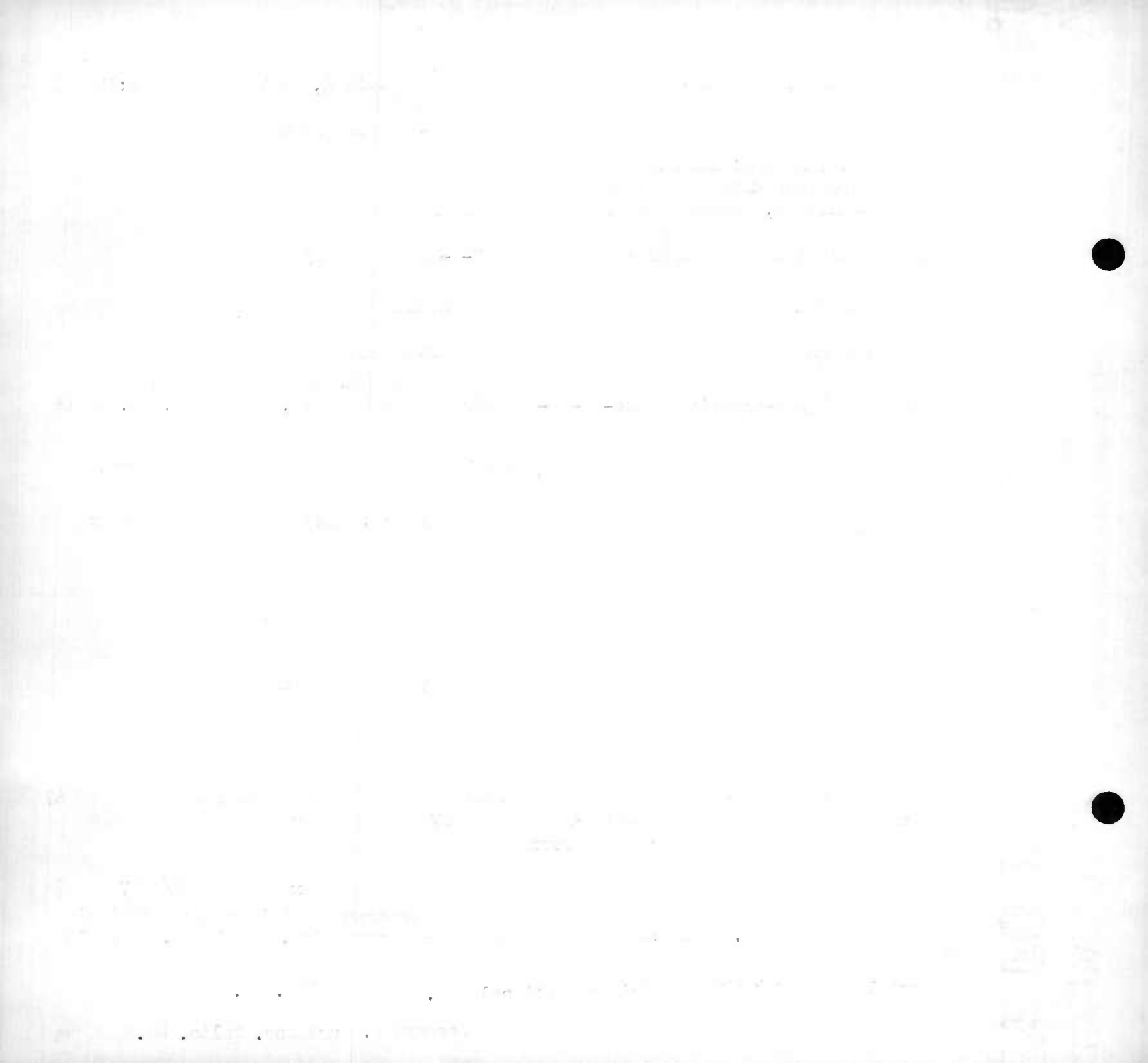
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6414</b>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <b>67 6414</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<div style="display: flex; justify-content: space-between;"> <div> <b>M.E. CASE NO.</b>  <b>1. NAME OF DECEASED</b>                      (Type or Print) <b>( E L L A ) ELIZABETH JECELIN</b> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <b>July 1, 1967</b> <span style="float: right;"><b>10<sup>20</sup> P. M.</b></span> </div> </div>					
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>   <b>1917 Deering Avenue...30</b> </div> <div> <b>(If not in hospital or institution, give street address or location)</b> </div> </div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b>  <b>Maryland</b> </div> <div> <b>B. COUNTY</b>  <b>Baltimore</b> </div> </div>		
<b>5. SEX</b> <b>female</b>			<b>6. RACE</b> <b>white</b>		<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>widowed</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>	
<b>13. FATHER'S NAME</b> <b>Joseph Novotny</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Josephine Bolek</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unk.</b>		<b>17. INFORMANT</b> <b>Mrs. Mary Jordan, 1917 Deering Ave, Balto, Md.</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>CAUSE OF DEATH</b> <b>(A) Anteriosclerotic heart disease with atrial fibrillation and congestive heart failure -</b> <b>(B) DUE TO</b> <b>(C)</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Undetermined</b>
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from June 20 1967 to July 1<sup>st</sup> 1967, that (I) (we) lost saw the deceased alive on June 30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Caesar J. Pellerano</b>				<b>23B. DATE SIGNED</b> <b>July 3<sup>rd</sup> 1967</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>Dr. Caesar J. Pellerano</b>				<b>23D. ADDRESS</b> <b>1311 Glenmont Rd., Balto., Md.</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>7/5/67</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Meadowridge Mem. Cemetery</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JUL 5 1967</b>		<b>25B. NAME OF REGISTRAR</b> <b>R. E. Taylor, M.D.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Leonard J. Ruck, Inc.-Balto., Md....14</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Elkridge, Md.</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6415</b>	
BIRTH NO. <b>67 6415</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>JEROME, RICHARD JOHN</b>			<b>JULY 4, 1967</b>   <b>6:10</b> <b>A</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>VETERANS ADMINISTRATION HOSPITAL</b> <b>3900 LOCH RAVEN BOULEVARD</b> <b>BALTIMORE, MARYLAND 21218</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
			D. STREET ADDRESS (If rural, give location) <b>4111 RAYMONN AVENUE</b>		
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7-3-24</b>	9. AGE (In years lost birthday) <b>43</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CRANE OPERATOR</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>
13. FATHER'S NAME <b>WALTER JEROME</b>			14. MOTHER'S MAIDEN NAME <b>MARIE DUBRIL</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b> <b>4/15/43-8/17/45</b>		16. SOCIAL SECURITY NO. <b>216-16-68-88</b>	17. INFORMANT ADDRESS <b>VETERANS HOSPITAL RECORDS</b> <b>3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218</b>		
18. <b>4-22-21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocarditis</b> DUE TO <b>Polymyositis (Probable)</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH <b>8 Months</b> <b>8 Months</b>
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>DO</del> (this hospital) attended the deceased from <b>JULY 3</b> 19 <b>67</b> to <b>JULY 4</b> 19 <b>67</b> , that <del>DO</del> (we) last saw the deceased alive on <b>JULY 4</b> 19 <b>67</b> and that in <del>(36)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>DO</del> (We) (did) <del>NOT</del> view the body after death.					
23A. SIGNATURE <i>R. H. Twining</i> <b>RALPH H. TWINING</b>				23B. DATE SIGNED <b>7/4/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>RALPH H. TWINING</b>				23D. ADDRESS <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd, Baltimore, Md 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/7/67</b>	24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>		25B. NAME OF REGISTRAR <i>Robert E. Farley, Jr.</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. Balto. Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

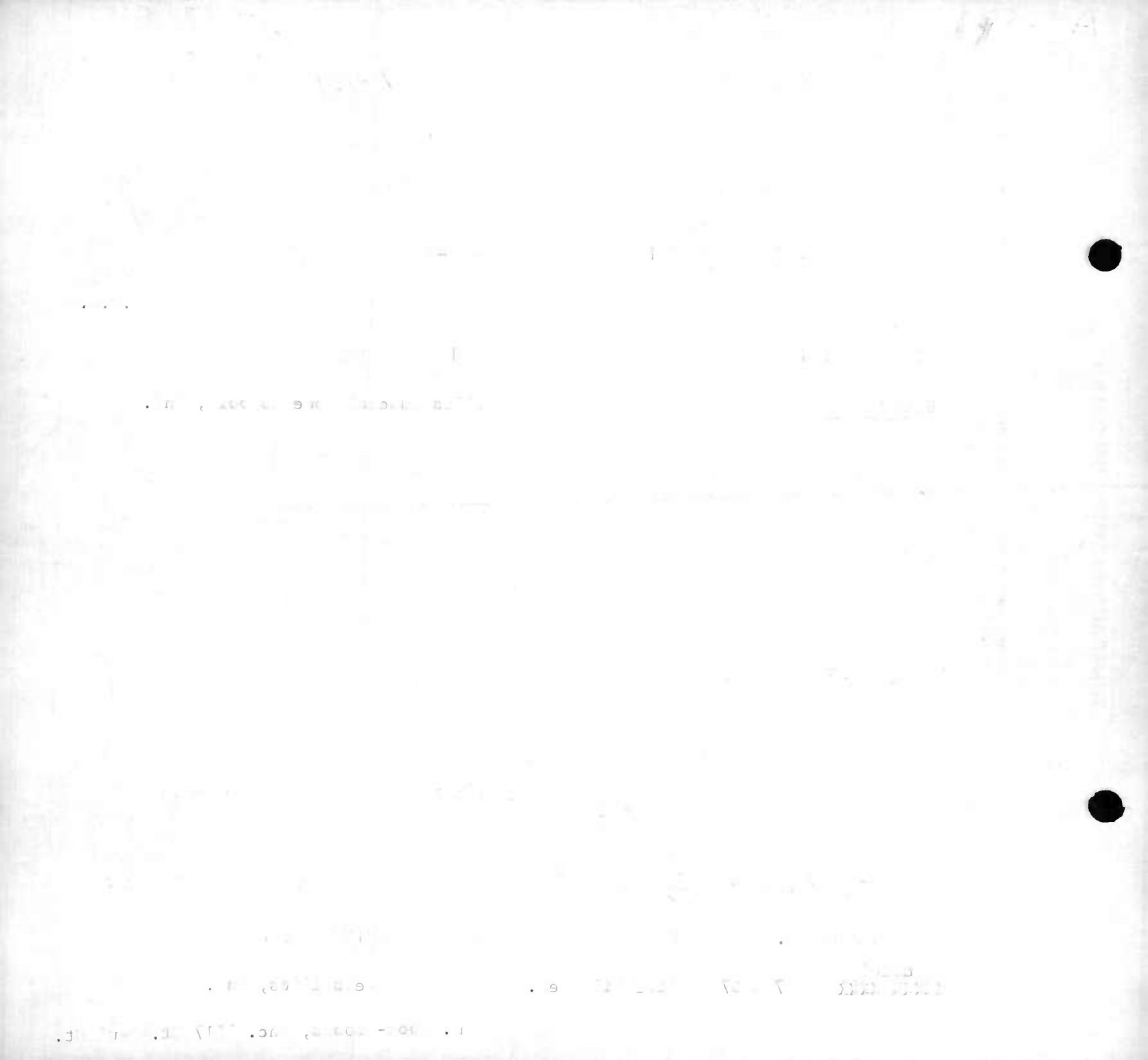
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">67 6416</span>	
BIRTH NO. <span style="font-size: 1.5em;">67 6416</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Mollie Collins</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">7-1-67</span> <span style="font-size: 1.2em;">3<sup>25</sup> P.</span> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">MERCY HOSPITAL.</span>			A. STATE <span style="font-size: 1.2em;">Md.</span> COUNTY <span style="font-size: 1.2em;">BALTIMORE CITY</span>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span>		
			D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">808 ST. PAUL ST.</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">W</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7-5-1896</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">71</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">None</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">?</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Md</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">GEORGE STROVEL</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">CATHERINE REDMOND.</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">28-103876</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MD-TOWN NURSING Home 808 ST. PAUL ST.</span>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">158X I</span>			CAUSE OF DEATH (A) <span style="font-size: 1.2em;">METASTATIC ADENOCARCINOMA</span> DUE TO <span style="font-size: 1.2em;">OF OMENTUM, PRIMARY UNK.</span> (B) <span style="font-size: 1.2em;">UNK.</span> DUE TO (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">6-29</span> 19 <span style="font-size: 1.2em;">67</span> to <span style="font-size: 1.2em;">7-1</span> 19 <span style="font-size: 1.2em;">67</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">7-1</span> 19 <span style="font-size: 1.2em;">67</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Leldon Sawbrake</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">7-1-67</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Leldon Sawbrake</span>				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">7/5/67</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Loudon Park Cem.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto. City, Md.</span>					
25A. DATE RECEIVED BY HEALTH DEPT. <span style="font-size: 1.2em;">JUL 5 1967</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Sawyer, M.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Wm. Cook-Brooks, Inc, 1217 St. Paul St.</span>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6417</b>	
BIRTH NO. <b>67 6417</b>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>DELBERT D. AIKENS</b>		2. DATE AND HOUR OF DEATH <b>7/4/67 7:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>INDIANA</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>OSGOOD</b>			
		D. STREET ADDRESS (If rural, give location) <b>V-12</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>2-16-10</b>	9. AGE (In years lost birthday) <b>57</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>?</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>THOMAS AIKINS</b>			
14. MOTHER'S MAIDEN NAME <b>MINTA DOWNEY</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>			
16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>Fallis Funeral Home Osgood, Ind.</b>			
18. <b>153.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>NONIZ</b>		CAUSE OF DEATH (A) <b>CARDIAL ARREST</b> DUE TO (B) <b>UNKNOWN.</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>6/21/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA OF CECUM</b>		20A. AUTOPSY? (Yes or No) <b>? YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/18/67</b> 19 to <b>7/4/67</b> 19, that (I) (we) last saw the deceased alive on <b>7/3/67</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stephen H. Bennett</b> M.D.		23B. DATE SIGNED <b>7/4/67</b>		23C. PHYSICIAN'S NAME (Type) <b>STEPHEN H. BENNETT</b> M.D.	
23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (specify) <b>XXXX XXXX</b>			
24B. DATE <b>7/8/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cliff Hill Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Versailles, Ind.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Wm. Cook-Brooks, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1217 St. Paul St.</b>	





FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6418</b>	
BIRTH NO. <b>67 6418</b>		GRACE		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED <b>Miriam Robinson</b>		2. DATE AND HOUR OF DEATH <b>July 3, 1967 16<sup>25</sup> A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Midtown Home Inc 808 St. Paul St. Baltimore Md 21202</b>		A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>11-02</b>		D. STREET ADDRESS (If rural, give location) <b>808 St. Paul St.</b>			
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>2/22/90</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Leon Weinberg</b>		14. MOTHER'S MAIDEN NAME <b>Marietta Hanna</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-22-00217</b>		17. INFORMANT ADDRESS <b>Homer E. Robinson 617 Parkwyrtth Ave Balt. Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio-Respiratory Failure massive Cerebral Hemorrhage Arteriosclerotic CVA Gen. Arteriosclerosis</b>		19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 2 1961</b> to <b>July 3 1967</b> , that (I) (we) last saw the deceased alive on <b>July 3 1967</b> and that (in my) <b>last</b> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>William D. Applefeld</b>				23B. DATE SIGNED <b>7/3/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>William D. Applefeld MD</b>		23D. ADDRESS <b>5507 Park Heights Dr.</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/5/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Springhill</b>	
24D. LOCATION (City, town, or county) (State) <b>Easton, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 5 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner MD</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6419		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6419	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 7/3/67 7:35 P.M.	
1. NAME OF DECEASED (Type or Print) Alexis Marshall Jones		2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital 33rd & Calvert Sts. Balt., Md. 21218		A. STATE Md. B. COUNTY Baltimore, Md. C. CITY OR TOWN Baltimore D. STREET/ADDRESS 600 Highwood Drive			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/14/91	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months Days 10 11 12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY CONTRACTOR ELECTRICAL		11. BIRTHPLACE (State or foreign country) ALABAMA	
13. FATHER'S NAME JOHN R. Jones		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-2842-A		17. INFORMANT MRS ATELKA J. WARD ADDRESS 1655 GLENEAGLE ROAD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		SUB DURAL HEMORRHAGE		AB Jemmy	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CARDIAC AORTIC STENOSIS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from 6/26 to 7/3 1967 that (I) (we) last saw the deceased alive on 7/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry J. Wechsner		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/3/67	
23C. PHYSICIAN'S NAME (Type) DR A GROSSMAN		23D. ADDRESS 4010 ST PAUL ST. Paul St., 2			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT JUL 5 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			

Handwritten notes at the top left, including "2000" and "1000".

Handwritten notes at the top right, including "1000" and "2000".

Handwritten notes in the middle left, including "1000" and "2000".

Handwritten notes in the middle right, including "1000" and "2000".

Handwritten notes in the lower middle left, including "1000" and "2000".

Handwritten notes in the lower middle right, including "1000" and "2000".

Handwritten notes at the bottom left, including "1000" and "2000".

Handwritten notes at the bottom right, including "1000" and "2000".

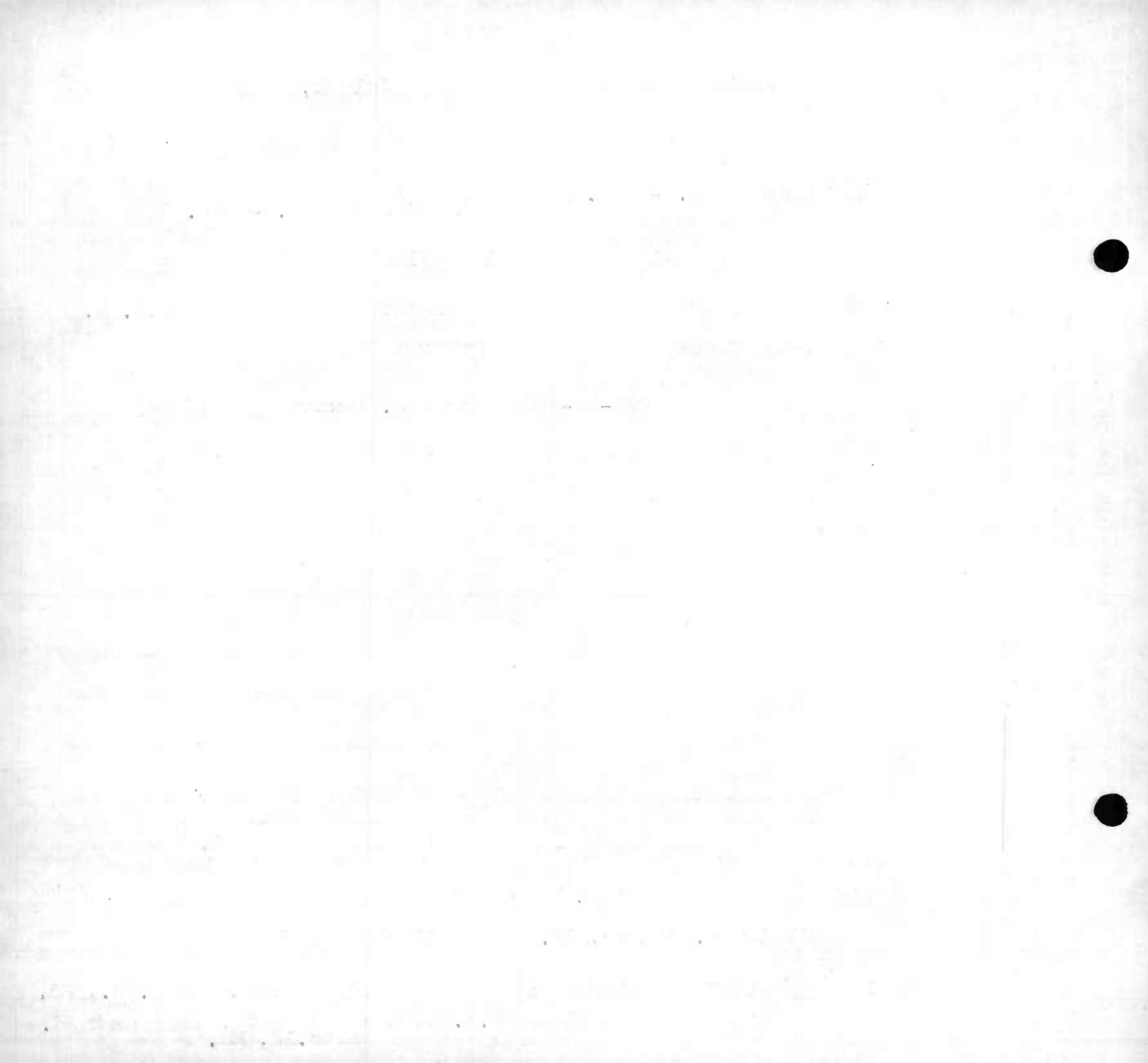
Handwritten notes at the bottom left, including "1000" and "2000".

Handwritten notes at the bottom right, including "1000" and "2000".

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">67 6420</span>	
BIRTH NO. <span style="font-size: 1.2em;">67 6420</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Nellie Chase Reus</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">July 1, 1967</span> <span style="font-size: 1.2em;">10 P.</span> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <span style="font-size: 1.2em;">00 416 Winston Ave. - Apt. 3</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.1em;">Baltimore</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">27-11</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.1em;">416 Winston Ave. - Apt. 3</span>		
5. SEX <span style="font-size: 1.1em;">F</span>	6. RACE <span style="font-size: 1.1em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.1em;">Widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.1em;">12/25/1884</span>	9. AGE (In years last birthday) <span style="font-size: 1.1em;">82</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.1em;">Own Home</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Maine</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.1em;">Charles August Chase</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Unknown</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">220-14-4880D</span>	17. INFORMANT <span style="font-size: 1.1em;">Henry J. Bowman</span> (Same)		
18. <span style="font-size: 1.2em;">443X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <span style="font-size: 1.2em;">Hypertensive Cardiovascular Disease</span> (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">11 years</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.1em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.1em;">Oct. 1956</span> to <span style="font-size: 1.1em;">July 1967</span> , that (I) ( <del>was</del> ) last saw the deceased alive on <span style="font-size: 1.1em;">15 May 1967</span> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Wm. H. Kammer, Jr.</span> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <span style="font-size: 1.2em;">3 July 1967</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">William H. Kammer, Jr.</span> M.D.		23D. ADDRESS <span style="font-size: 1.1em;">6011 York Road</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">7/5/1967</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.1em;">Druid Ridge</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Pikesville, Balto. Co., Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUL 5 1967</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Salyers</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</span>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">67 6421</span>	
BIRTH NO. <span style="font-size: 1.5em;">67 6421</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Jessie H. Shane</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">June 30, 1967</span> <span style="float: right;">12:45 P M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <span style="font-size: 1.1em;">Maryland</span>			
<span style="font-size: 1.1em;">90</span> <span style="font-size: 1.1em;">House in Pines- Belvedere</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		<span style="font-size: 1.1em;">Baltimore</span>			
		D. STREET ADDRESS (If rural, give location)			
		<span style="font-size: 1.1em;">3702 Greenmount Ave.</span>			
5. SEX <span style="font-size: 1.1em;">F</span>	6. RACE <span style="font-size: 1.1em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.1em;">Never Married</span>	8. DATE OF BIRTH <span style="font-size: 1.1em;">8/27/1888</span>	9. AGE (In years lost birthday) <span style="font-size: 1.1em;">78</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<span style="font-size: 1.1em;">Retired-Saleswoman</span>		<span style="font-size: 1.1em;">Wyman's Shoe Store</span>		<span style="font-size: 1.1em;">Baltimore, Md.</span>	
13. FATHER'S NAME <span style="font-size: 1.1em;">North M. Shane</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Margaret Gregner</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">216-46-1112T</span>		17. INFORMANT ADDRESS <span style="font-size: 1.1em;">Edward M. Shane (Same)</span>	
18. <span style="font-size: 1.2em;">443 X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <span style="font-size: 1.1em;">Acute Pericard Embolus</span> <span style="font-size: 1.1em;">Hypertensive Cardiovascular</span> (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.1em;">4 days 8.0 hrs.</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">no.</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">Oct 18 1965</span> to <span style="font-size: 1.1em;">June 30 1967</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">June 28 19 67</span> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.1em;">Lester N. Kolman</span> M.D.				23B. DATE SIGNED <span style="font-size: 1.1em;">7/3/67</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">Lester N. Kolman</span> M.D.				23D. ADDRESS <span style="font-size: 1.1em;">3700 Park Heights Ave.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">7/5/1967</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.1em;">Loudon Park</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">JUL 5 1967</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">Robert E. Jenkins</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.1em;">H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</span>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

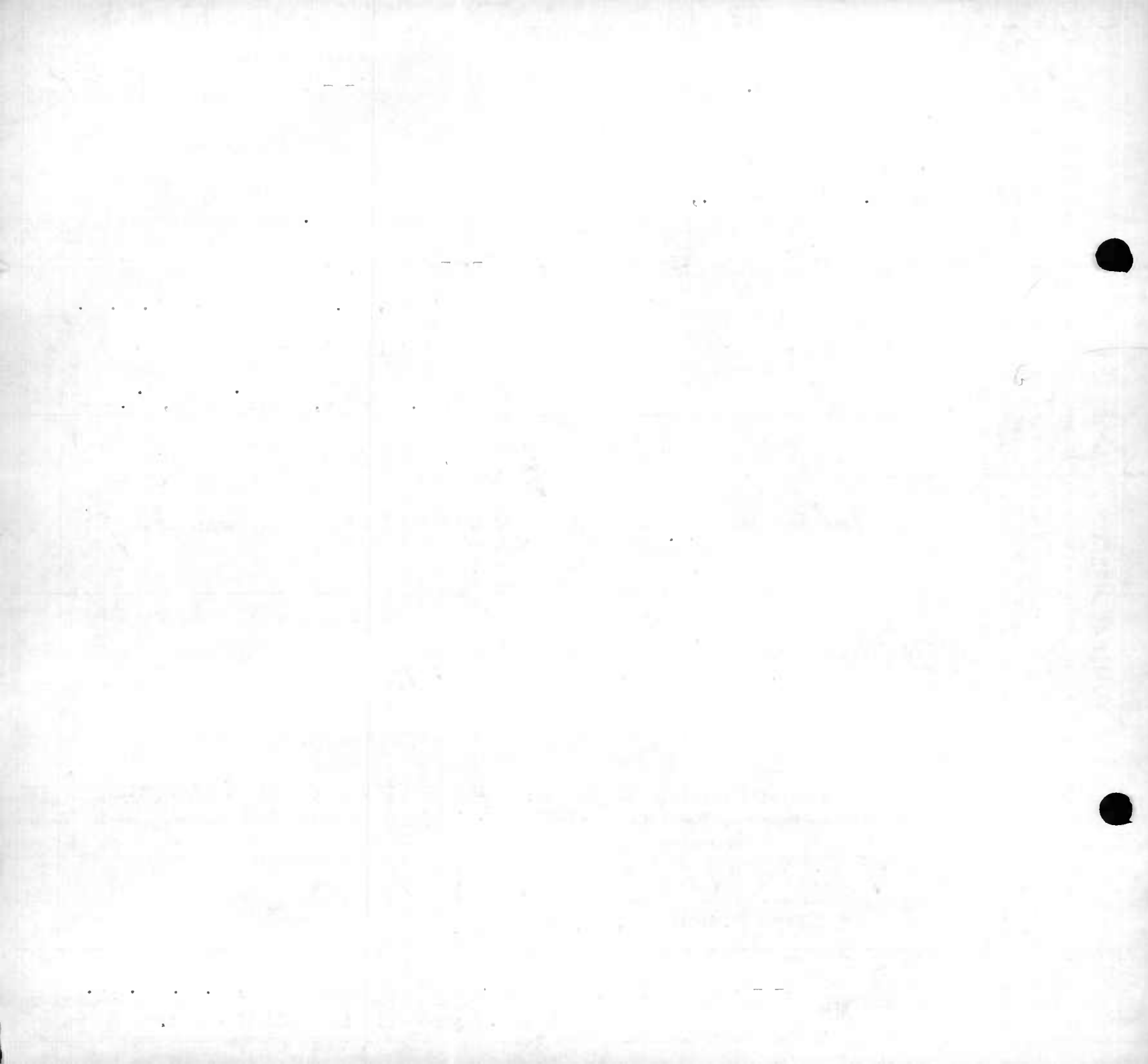
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6422</b>	
BIRTH NO. <b>67 6422</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Costa, Phillip NMI</b>		2. DATE AND HOUR OF DEATH <b>July 2, 1967 8:30A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd</b> <b>Baltimore, Maryland 21218</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>11 North High Street</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>7/1/25</b>	9. AGE (In years last birthday) <b>42</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>various</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Costa</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Costa nee Provenzano</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1/25/43 to 4/14/46</b>			
16. SOCIAL SECURITY NO. <b>219-18-2292</b>		17. INFORMANT <b>Records</b> ADDRESS <b>Veterans Administration Hospital, Balto., Md.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute pulmonary edema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute left heart failure</b> <b>Cirrhosis of liver, advanced</b>		INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 2, 19 67</b> to <b>July 2, 19 67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 2, 19 67</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death.					
23A. SIGNATURE  ERNESTO P. SMITH				23B. DATE SIGNED <b>7/3/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ERNESTO P. SMITH</b>		23D. ADDRESS <b>Veterans Administration Hospital</b> <b>Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/6/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>			
24F. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		24G. FUNERAL DIRECTOR <b>Loring Byers</b>			
24H. ADDRESS <b>8728 Liberty Rd</b>		24I. ADDRESS <b>Handallston</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6423</b>	
BIRTH NO. <b>67 6423</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MINNIE S. CLARK</b>		2. DATE AND HOUR OF DEATH <b>7-2-67 5:20 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>House in the Pines Nursing Home</b> <b>2525 W. Belvedere Ave.,</b>		D. STREET ADDRESS (If rural, give location) <b>1603 Jackson St.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>7-24-1891</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Ludwig Mueller</b>			14. MOTHER'S MAIDEN NAME <b>Wilhelmina Miller</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Louis M. Mueller, Philadelphia, Pa. 19142</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b>		CAUSE OF DEATH (A) DUE TO <b>acute M.I.</b> (B) DUE TO <b>chronic M.I.</b> (C) <b>acute M.I.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yr.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 21, 1965</b> to <b>July 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 2, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lester N. Kolman</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>7/3/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>LESTER N. KOLMAN, M.D.</b>		23D. ADDRESS <b>3700 PARK HEIGHTS AVENUE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-5-67</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Ritchie Hwy, A. A. Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Flynn &amp; Fleming 1422 Light St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6424				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6424	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LONGEST, BRIAN C.</b>				2. DATE AND HOUR OF DEATH <b>&amp;+* &amp; 7-1-67 12:05PM M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO Co.</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21207 5300</b>			
				D. STREET ADDRESS (If rural, give location) <b>1930 BROOKDALE ROAD</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>9-4-59</b>	9. AGE (In years last birthday) <b>7</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES LONGEST</b>				14. MOTHER'S MAIDEN NAME <b>BARBARA HILDEBRANDT</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>HOSP. RECORDS</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>UREMIA - AMURIA</b>				CAUSE OF DEATH (A) DUE TO <b>widely metastatic Wilms tumor</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 8</b> 19 <b>67</b> to <b>July 1</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>July 1</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>HERBERT M. SWICK</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>July 1 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>HERBERT M. SWICK</b>				23D. ADDRESS M.D. <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7/5/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>ST JOHN</b>		24D. LOCATION (City, town, or county) (State) <b>ELLICOTT CITY MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MA</b>		25C. FUNERAL DIRECTOR <b>E. S. MALNABB</b>		ADDRESS <b>30 FREDERICK RD 21228</b>	

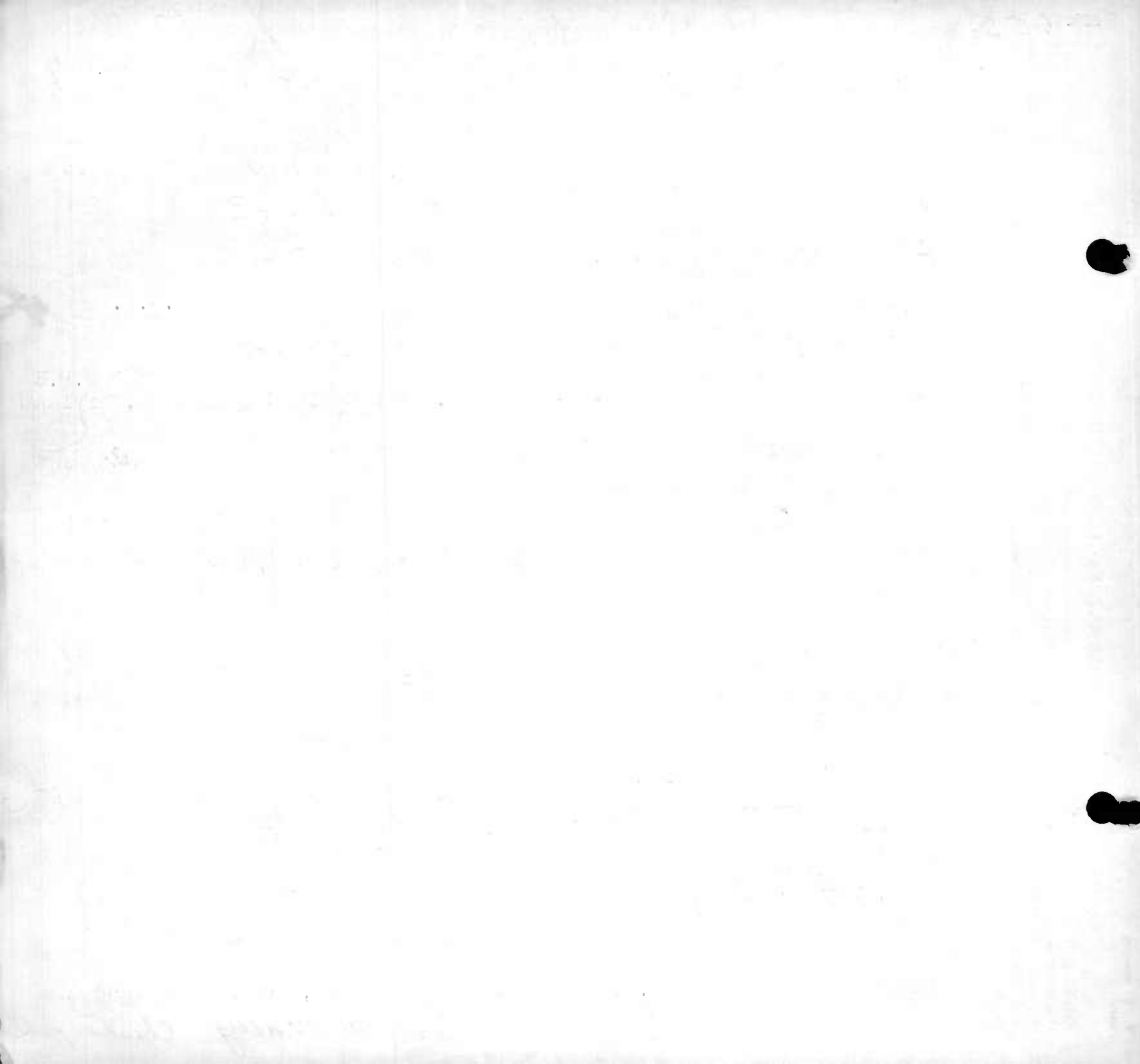
Univ. - America  
3rd 1st

*[Faint handwritten notes, possibly bleed-through from the reverse side.]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 6425					Registered No. 67 6425					
BIRTH NO.					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>HELEN BESSIE FREEMAN</b>					2. DATE AND HOUR OF DEATH <b>6-29-67 7:50 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY HOSP</b>					A. STATE <b>MD</b> B. COUNTY <b>KENT CO.</b>					
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>CHESTERTOWN 64-00</b>					
					D. STREET ADDRESS (If rural, give location) <b>Rt. 2 - Box 23</b>					
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never Married</b>		8. DATE OF BIRTH <b>2-28-31</b>	9. AGE (In years last birthday) <b>36</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>T. HOMAS R. FREEMAN</b>				14. MOTHER'S MAIDEN NAME <b>SOPHIE L. GRAVES</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>214-28-2710</b>		17. INFORMANT <b>Mrs. Sarah Caulk Chestertown, Maryland</b>				ADDRESS <b>R.F.D.</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>					INTERVAL BETWEEN ONSET AND DEATH					
(A) <b>ASPIRATION</b> DUE TO					<b>30 minutes</b>					
(B) <b>CEREBRAL METASTASIS</b> DUE TO					<b>~ 1 month</b>					
(C) <b>BRONCHIOGENIC CARCINOMA</b> DUE TO					<b>~ several mos</b>					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>6-16</b> 19 <b>67</b> to <b>6-29</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-29</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>[Signature]</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>6-29-67</b>		
23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>					23D. ADDRESS <b>UNIV. HOSP, BALT, MD.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/2/1967</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Pisgah Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Kent, County Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>			25C. FUNERAL DIRECTOR <b>[Signature]</b>					
					ADDRESS <b>Chestertown, Md</b>					

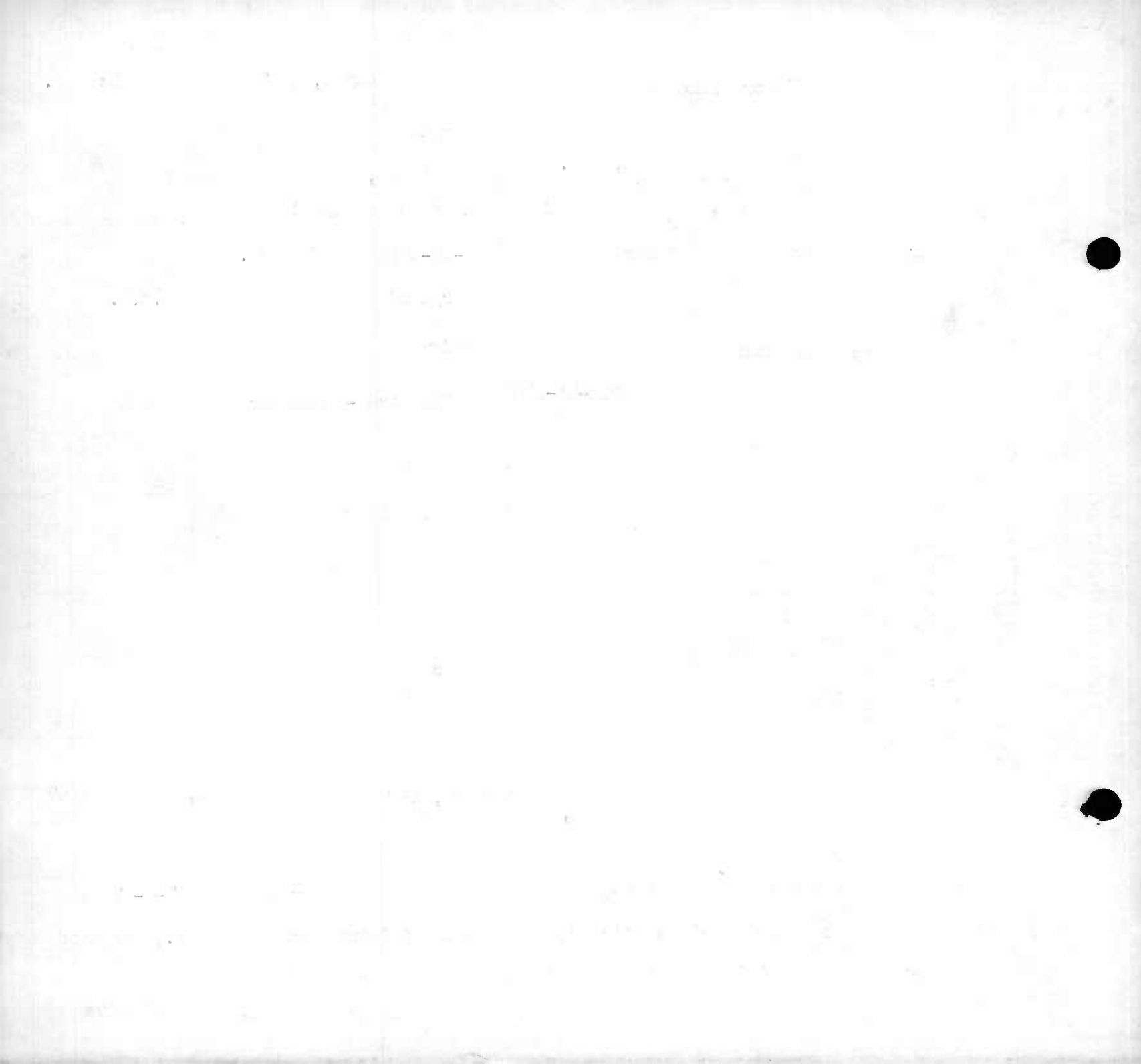




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

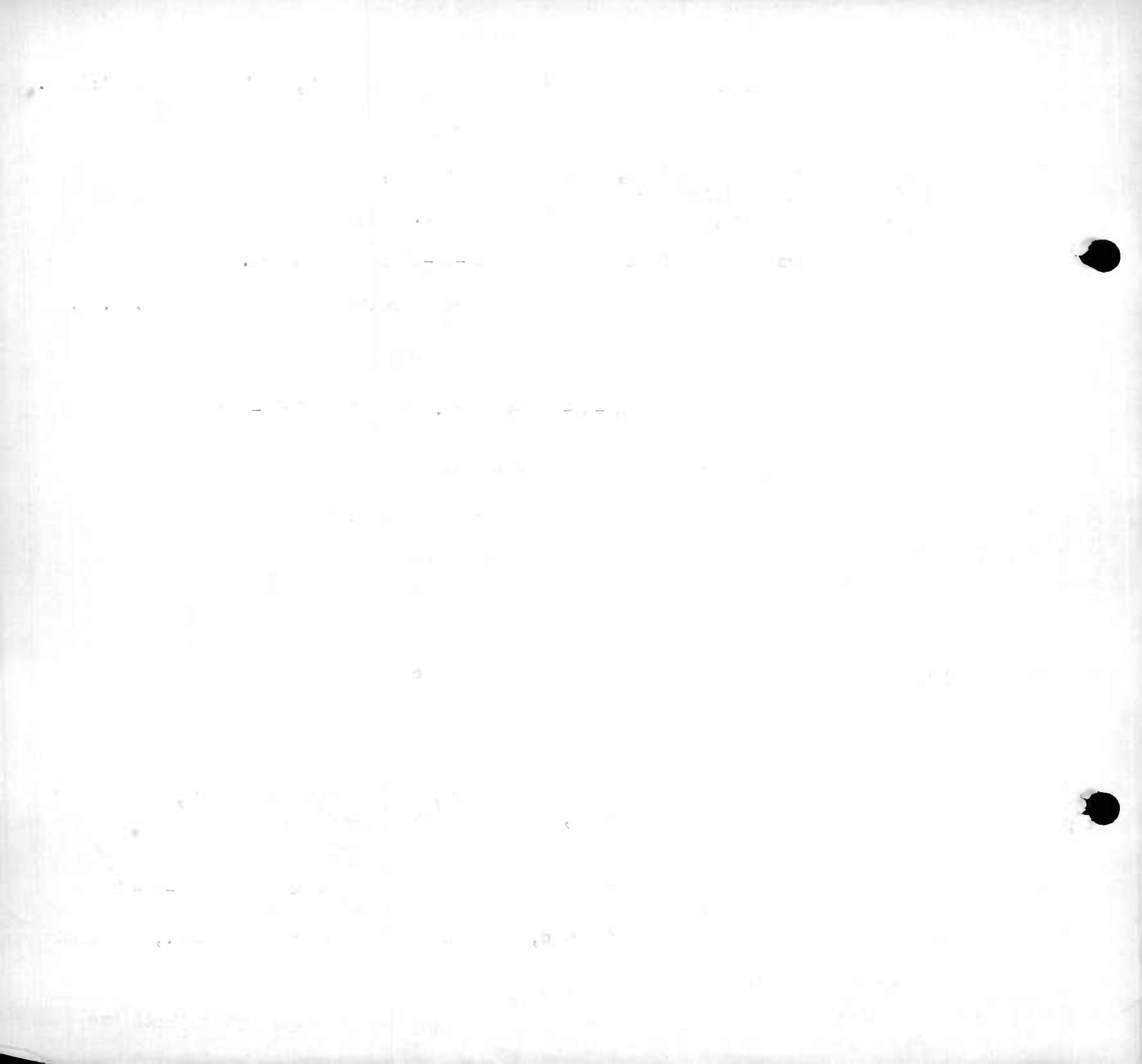
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 6426</span>	
BIRTH NO. <span style="float: right;">67 6426</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <span style="float: right;">Victor Buchanan</span>			July 1, 1967 <span style="float: right;">3:45 P. M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  39  Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217			A. STATE Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 14-03		
			D. STREET ADDRESS (If rural, give location) 1805 Brunt Street		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8-10-1892	9. AGE (In years lost birthday) 74 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Buchanan			14. MOTHER'S MAIDEN NAME Alice		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-14-1348	17. INFORMANT Anita Ford - daughter		ADDRESS SAME
18. <span style="float: right;">15-6-1 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Carcinomatosis</u> DUE TO  <u>Carcinoma of liver</u> (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 30, 1967</u> 19 <u>67</u> to <u>July 1, 1967</u> that (I) (we) last saw the deceased alive on <u>July 1, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>S. Setasuban</i>				23B. DATE SIGNED 7-3-67	
23C. PHYSICIAN'S NAME (Type) S. SETASUBAN		23D. ADDRESS M.D. 1514 Division Street Balto., Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/5/67	24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetry		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1967		25B. NAME OF REGISTRAR Robert E. Jarkema		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6427		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6427	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Wallace Hall (E)				June 27, 1967		4:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
39 Provident Hospital, Inc.		1415 Division Street		Maryland			
Baltimore, Maryland 21217				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore,		13-03	
				D. STREET ADDRESS (If rural, give location)			
				1004 W. North Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Male	Negro	Single	12-12-1885	81 yrs.	Laborer	North Carolina	U. S. A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		218-18-2968-A		Mrs. Ernestine Rich - Friend		SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)				(A) Heart Arrest			
ANTECEDENT CAUSES				(B) Cerebrovascular Accident			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Hypertension			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from June 27, 1967 to June 27, 1967, that (I) (we) last saw the deceased alive on June 27, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Lizarazo M.D.				6-28-67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Lizarazo, M.D.				1514 Division Street Balto., Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/1/67		Mt. Calvary Cemetery		A A County Md	
25A. DATE RECEIVED		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 6 1967		Adolphus Halstead		Adolphus Halstead		1206 W North Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6428				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6428	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				RA YMOND WAGNER WRIGHT		JULY 2, 1967 4:10 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE MARYLAND		B. COUNTY Howard Co.	
SAINT AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		JESSUP 63-00	
D. STREET ADDRESS (If rural, give location)				337 MOUNTVIDEO ROAD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)
MALE	WHITE	MARRIED	07/31/09	57	CARPENTER (UNEMP.)		MARYLAND
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?		
CARPENTER (UNEMP.)					U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WALTER WRIGHT				EMMA WAGNER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				NOT SHOWN		ST. AGNES RECORDS WILKENS & CATON AVES.	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				6 days			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) gangrene extensive small intestine			
ANTECEDENT CAUSES				(B) Superior mesenteric Thrombosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Arterian Sclerosis			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Acute Myocardial infarction Aspiration gastric Contents			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
6-29-67		Acute Abdomen		yes		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from 6/9 1967 to 7/2 1967, that (X) (we) lost saw the deceased alive on 7/2 1967 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXXX) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Carl H. Mackey				7-3-1967			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		July 6, 1967		Cedar Hill		Suitland Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 6 1967		Robert E. Finken, M.D.		Robert E. Wilhelm		4398 Suitland Rd. Suitland Md.	

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P-362

67 6429

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 6429

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)  
DANIEL

HENRY PATTERSON, JR

2. DATE AND HOUR PRONOUNCED DEAD

July 3, 1967

6:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

418 N. Pine Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

429 Pine Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

9/5/16

9. AGE (In years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labourer

10B. KIND OF BUSINESS OR INDUSTRY

Store

11. BIRTHPLACE (State or foreign country)

n.c.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Daniel H. Patterson, Jr

14. MOTHER'S MAIDEN NAME

Flossie Jacobs

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W. II

16. SOCIAL  
SECURITY NO.

240-10-7089

17. INFORMANT

Flossie Patterson-535 Wildwood Pkwy

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Fatty Alteration of Liver

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/4/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7/10/67

23C. NAME of CEMETERY or CREMATORY

Balto. Nat.

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 8 1967

Robert E. Fink

Wm. J. Schatman, Jr - 1701 M. E. Carroll St

8/5/12

September

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There

between

Charles H. Patterson, Jr. & his friends

per. 11.00

2010-11-11

11.00

11.00

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A-550

BALTIMORE CITY HEALTH DEPARTMENT				67 6430	
BIRTH NO. 67 6430				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6430	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>EILEEN Joyce AMMON</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>July 3, 1967 3:10 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Pennsylvania</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Media</b> D. STREET ADDRESS (If rural, give location) <b>711 N. Providence Road</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>Mar. 20, 1960</b>	9. AGE (in years last birthday) <b>7</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Phila. Pa.</b>	
13. FATHER'S NAME <b>Robert D. Ammon</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Ammon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Richard Ammon (Uncle)</b> ADDRESS <b>Cape St. Clair Maryland</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>(A) m Cranio-Cerebral Injuries</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Old Mill Bottom Road intersection at Route 50</b>	
21D. TIME OF INJURY (APPROX.) <b>July 3, '67 12:45 P. m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Passenger in car - tractor trailer collision</b>	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>7/4/67</b>					
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>JULY 7 1967</b>		23C. NAME OF CEMETERY or CREMATORY <b>GLENWOOD CEM.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		24C. FUNERAL DIRECTOR <b>Beall Funeral Home</b> ADDRESS <b>12 West St Annapolis, Md.</b>	

UNITED STATES  
NATIONAL ARCHIVES

Just 7th Avenue Cn

Broomer 10/1/76  
[Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 6431</b>	
BIRTH NO. <b>36</b>		67 6431	
<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>JOHN W. SNYDER</b>		<b>7-2-67 7:50 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <b>3 THE JOHNS HOPKINS HOSPITAL</b>		A. STATE <b>PENNSYLVANIA</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>McCONNELLSBERG</b> D. STREET ADDRESS (If rural, give location) <b>403 LINCOLN WAY EAST</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>2-18-91</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>76</b>
13. FATHER'S NAME <b>JAMES SNYDER</b>		14. MOTHER'S MAIDEN NAME <b>AMANDA GORDON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Elmer Snyder</b>
18. <b>45-1X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Dissecting Aneurysm, Thoracic Aorta</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Arteriosclerotic Cardiovascular Disease</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
<b>none</b>			<b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>June 30 1967</b> to <b>July 2 1967</b> , that (I) (we) last saw the deceased alive on <b>July 2 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <b>Daniel Weisz</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>July 2 1967</b>
23C. PHYSICIAN'S NAME (Type) <b>DANIEL WEISZ</b>		23D. ADDRESS M.D. <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/5/67</b>	24C. NAME OF CEMETERY or CREMATORY <b>Pleasant Ridge</b>	24D. LOCATION (City, town, or county) (State) <b>Fulton Co PA</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	25C. FUNERAL DIRECTOR ADDRESS <b>J. F. Eline &amp; Sons Reisterstown, Md.</b>

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6432				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6432			
1. NAME OF DECEASED (Type or Print) <u>Thomas J.A.S. Walsh Sr.</u>				2. DATE AND HOUR OF DEATH <u>7/3/67</u> <u>9:30 AM.</u>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secour Hospital</u> <u>34</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>9.9.C.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Linthicum</u> D. STREET ADDRESS (If rural, give location) <u>907 Wanda Ave.</u> <u>52-00</u>							
5. SEX <u>M</u>		6. RACE <u>white</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>		8. DATE OF BIRTH <u>1/2/04</u>		9. AGE (In years lost birthday) <u>63</u>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. City Fire Dept</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Thos P. Walsh</u>				14. MOTHER'S MAIDEN NAME <u>Catherine A. Cummings</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-22-9514</u>				17. INFORMANT ADDRESS <u>Mrs. Ethel A. Walsh, 907 Wanda Rd. Linthicum</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>420.1</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <u>Aspiration pneumonia, right lower lobe w. septicemia.</u> DUE TO (B) <u>Recent and healed infarctions, left ventricle + septum</u> DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 weeks</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes.</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (X) (this hospital) attended the deceased from <u>June 12</u> 19 <u>67</u> to <u>July 3</u> 19 <u>67</u> , that (X) (we) last saw the deceased alive on <u>July 2</u> 19 <u>67</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did not) view the body after death.											
23A. SIGNATURE <u>Bravo</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>7/3/67</u>			
23C. PHYSICIAN'S NAME (Type) <u>Bon Secours Hosp.</u>				23D. ADDRESS <u>Bon Secours Hosp.</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-7-1967</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		ADDRESS					

1800 2000 2200

# FUNERAL DIRECTOR: IMPORTANT

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67 6433		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6433	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				LAMBERT ANNIE E.	
2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
7-3-67 9:45PM		LAMBERT ANNIE E.			
9:45 P.M.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
A. STATE		B. COUNTY			
		1421 ELMTREE ST BALTO 26 MD			
C. CITY OR TOWN		D. STREET ADDRESS			
(If outside city limits, write RURAL and give township)		(If rural, give location)			
BALTO 26 MD		1421 ELMTREE ST			
25-05					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
FEMALE	WHITE	WIDOWED, DIVORCED (specify)	6-23-00	67	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Tipper		Umbrella	Baltimore, Md.	USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Louis Lantz			Annie E. Deiter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		
No		212 09 8318A	ST AGNES RECORDS WILKENSE & CATON AVE		
			EMERGENCY DEPT. X 516		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (X) (this hospital) attended the deceased from 7-3-67 to 7-3-67, that (X) (we) lost saw the deceased alive on 7-3-67 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above (XX) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
J. KORBULY				7-3-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
J. Korbuly					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	7/7/67	Cedar Hill Com.	Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
JUL 6 1967	Robert E. Fisher, M.D.	JOHN F. DENNY, INC.		715 Light St.	

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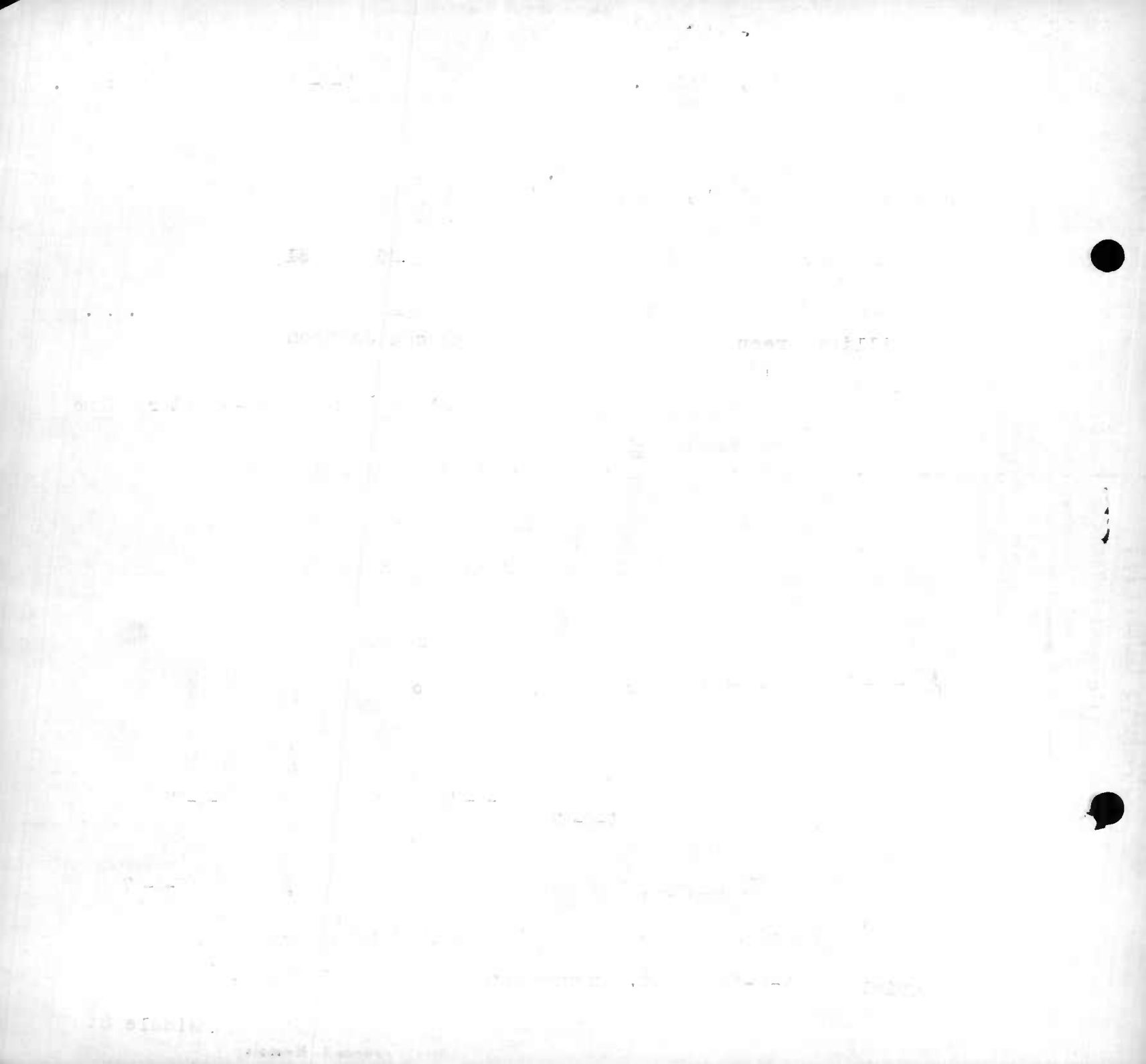
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

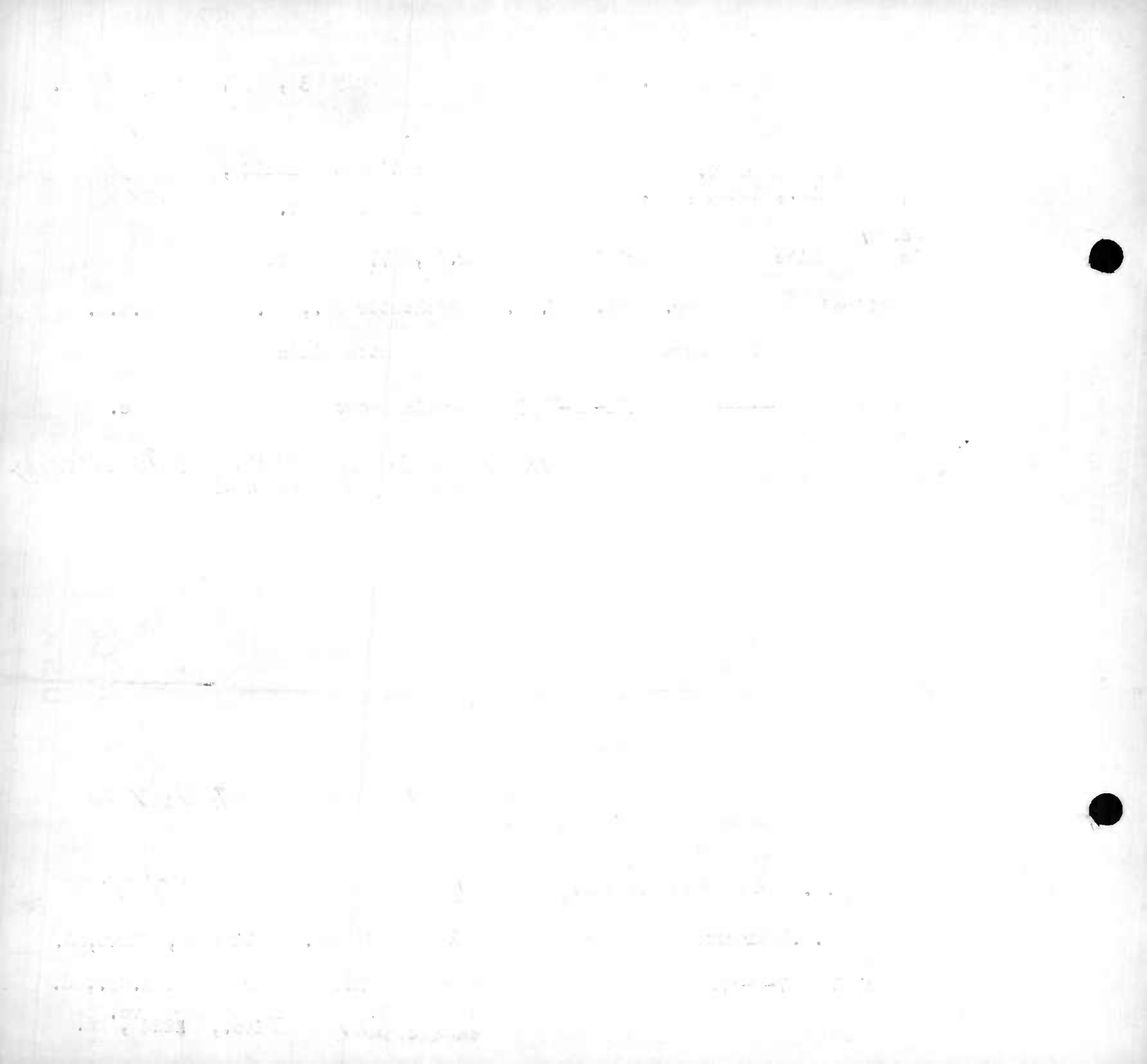
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6434</b>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <b>67 6434</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Adkins, Fannie E.</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>7-1-67</b> <b>9:30 A.</b> M.		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital, Inc.</b> <b>Baltimore, Maryland 21217</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>Baltimore</b> <b>D. STREET ADDRESS</b> (If rural, give location) <b>1331 Argyle Avenue</b>		
<b>5. SEX</b> <b>Female</b>	<b>6. RACE</b> <b>Negro</b>	<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>12-12-86</b>	<b>9. AGE</b> (In years lost birthday) <b>81</b>	<b>If Under 1 Yr.</b> Months Days <b>If Under 24 Hrs.</b> Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>	
<b>13. FATHER'S NAME</b> <b>William Green</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Rebecca Johnson</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> <b>Florence Adkins (Step-Daughter)</b> <b>Same</b> ADDRESS		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Atelectasis of left lung</b> <b>Post op after hip nailing</b> <b>Fracture of right hip</b> <b>INTERVAL BETWEEN ONSET AND DEATH</b>			<b>19. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Fracture of the uterus</b>		
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b> <b>6-15-67</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>Hip Fracture (Right)</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>No</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>1331 Argyle Ave</b>	
<b>21D. TIME OF INJURY (APPROX.)</b> <b>6-4-67</b>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <b>Fell to the floor entering bedroom inflicting her hip.</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 6-5-67 19 to 7-1-67 19, that (I) (we) last saw the deceased alive on 7-1-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>A. Setasuban</b> M.D.			<b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Stoff Phys.</b> <input checked="" type="checkbox"/>		<b>23B. DATE SIGNED</b> <b>7-1-67</b>
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>Setasuban</b>			<b>23D. ADDRESS</b> <b>1514 Division Street</b>		
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>7-5-67</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Mt. Auburn Cem</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md</b>		<b>25A. DATE REC'D BY HEALTH DEPT</b> <b>JUL 6 1967</b>			
<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, M.D.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Frances A. Hearnsey</b>		<b>578 ADDRESS</b> <b>Biddle St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6435</b>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <b>67 6435</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>FREDERICK L. MOORE</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>July 3, 1967 1:30 P. M.</b>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <b>522 Savage St.</b>  <b>Balto., 12224, Md.</b> </div> <div> <b>(If not in hospital or institution, give street address or location)</b> </div> </div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) <b>A. STATE</b> <b>Md.</b> <b>B. COUNTY</b>		
<b>5. SEX</b> <b>Male</b>			<b>6. RACE</b> <b>White</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</b> <b>Married</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Amer. Smelt. &amp; Ref. Co.</b>		<b>8. DATE OF BIRTH</b> <b>Mar. 18, 1877</b>	
<b>13. FATHER'S NAME</b> <b>? Moore</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Etta Mills</b>		<b>9. AGE</b> (In years last birthday) <b>90</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Dorchester Co., Md.</b>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>212-10-1853</b>		<b>17. INFORMANT</b> <b>Jerusia Moore</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>7-22-11</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <b>(A) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b> <b>(B) DUE TO</b> <b>(C) DUE TO</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>12 MONTHS</b>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 6/7/67 to 7/3/67, that (I) (we) last saw the deceased alive on 6/7/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>W.E. Baermann</b> M.D.				<b>23B. DATE SIGNED</b> <b>7/3/67</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>W.E. Baermann</b> M.D.				<b>23D. ADDRESS</b> <b>3401 Dundalk Ave. Baltimore, 21222, Md.</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>7-6-67.</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Oak Lawn Cemetery</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JUL 6 1967</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Farley, M.D.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Charles J. Seiler</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>7225 Eastern Blvd. Ba. Co., Md.</b> <b>6224 Eastern Ave. Balto., 21224, Md.</b>					



BIRTH NO. **67 6436** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 6436**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>RICHARD SCHLINE (Richard Edward Schline Sr)</b>			2. DATE AND HOUR PRONOUNCED DEAD <b>July 4, 1967 4:25 p.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>St. Agnes Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1160 Monroe Circle 21225</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>April 28, 1928</b>	9. AGE (In years last birthday) <b>39</b>	If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Helper</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Harbison - Walker Fire Brick</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Howard Schline</b>			14. MOTHER'S MAIDEN NAME <b>Melissa Tawes</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>214-24-7736</b>		
17. INFORMANT <b>Mrs. Katherine Schlines</b>			ADDRESS <b>21225 1160 Monroe Circle</b>		

18. <b>E900.0</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Craniocerebral injury</b> DUE TO (A) <b>Craniocerebral injury</b> (B) <b>Due to</b> (C) <b>Due to</b> INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1160 Monroe Court</b>	
21D. TIME OF INJURY (APPROX.) <b>4 29-30? '67 ?</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell down cellar steps</b>	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>July 5, 1967</b>					

23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>7/8/67</b>		23C. NAME of CEMETERY or CREMATORY <b>Glen Haven Memorial</b>		23D. LOCATION (City, town, or county) (State) <b>Glen Burnie A. A. Co.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		24C. FUNERAL DIRECTOR <b>McCully Funeral Home</b>		ADDRESS <b>Patapsco Ave. &amp; 3rd St. 21225</b>	

WALSH &amp; WOODRUFF

25/6/96 10:10 AM

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67 6437

BALTIMORE CITY HEALTH DEPARTMENT

67 6437

BIRTH NO. 67-08123 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) KEVIN D. BOERNER		2. DATE AND HOUR PRONOUNCED DEAD July 3, 1967 10:40P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTIMORE GENERAL (DOA)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 20-33 D. STREET ADDRESS (If rural, give location) 2341 Sidney Avenue				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH April 25, 1967	9. AGE (In years last birthday) 2	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME George Boerner		14. MOTHER'S MAIDEN NAME Betty Kelsner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Doris Mc Guigan		ADDRESS Same		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Congenital Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/4/67						
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7-5-67		23C. NAME of CEMETERY or CREMATORY Glen Haven		23D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md.
24A. DATE REC'D BY HEALTH DEPT. JUL 6 1967		24B. NAME OF REGISTRAR Robert E. Taylor, Jr.		24C. FUNERAL DIRECTOR Mc Cully		ADDRESS 130 E. Fort Ave

WALTON & WOOD

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R-152

BALTIMORE CITY HEALTH DEPARTMENT				67 6438					
BIRTH NO. 67 6438				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6438					
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>WILLIAM</b>		ROBINSON		2. DATE AND HOUR PRONOUNCED DEAD <b>July 4, 1967</b>		<b>2:50 A. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>2408 Barclay Street</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Pennsylvania</b> B. COUNTY <b>Morton</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>113 Harding Avenue</b> D. STREET ADDRESS (If rural, give location) <b>113 Harding Avenue</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>3-16-47</b>	9. AGE (In years last birthday) <b>20</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles Robinson</b>				14. MOTHER'S MAIDEN NAME <b>Betty Williams</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>159365295</b>		17. INFORMANT <b>Charles Robinson</b> ADDRESS <b>113 Harding Avenue</b>					
MEDICAL CERTIFICATION  18. <b>E 9821 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION <b>7/4/67</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>2</b> 20A. AUTOPSY? (Yes or No) <b>Yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b> 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <b>2</b> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>In front of 2408 Barclay Street</b> 21D. TIME OF INJURY (APPROX.) <b>7/4/67 2:45 A.</b> 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? <b>stabbed during alceration 12-03</b> 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>7/4/67</b>				CAUSE OF DEATH (A) <b>Cardiac Tamponade</b> DUE TO <b>stab wound of chest involving the heart.</b> (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
				23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 23B. DATE <b>7-8-67</b> 23C. NAME of CEMETERY or CREMATORY <b>Chestnut Grove Cem.</b> 23D. LOCATION (City, town, or county) (State) <b>Westchester, Pennsylvania</b> 24A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b> 24B. NAME OF REGISTRAR <b>2408 Barclay St.</b> 24C. FUNERAL DIRECTOR <b>Kelson Funeral Home 1348 Calhoun St</b> ADDRESS					

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 6439 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6439

G-650

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>DONALD GREEN</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>July 4, 1967 6:55 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2135 Division Street</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2135 Division Street</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>single</b>	8. DATE OF BIRTH <b>1-18-36</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>31</b>
13. FATHER'S NAME <b>John Green</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213300723</b>	14. MOTHER'S MAIDEN NAME <b>Lavina</b>
17. INFORMANT <b>John Green</b>		ADDRESS <b>2946 Arunah Avenue</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Death during epileptic seizure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>7-8-67</b>	23C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>
24A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		24B. NAME OF REGISTRAR <b>Philip E. Taylor, M.D.</b>	23D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
24C. FUNERAL DIRECTOR <b>Kelson Funeral Home</b>		ADDRESS <b>1348 Calhoun St.</b>	

WALLLEY BOIRGE

2nd MAINTENANCE

1  
R-234

67 6440

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 6440

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ROBERT J. RAGSDALE, JR. 2. DATE AND HOUR PRONOUNCED DEAD 6-10-67 6:00 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

00 JOHN STREET OPENING - Penna. R. R. D. STREET ADDRESS (If rural, give location) 2006 Cliffwood Avenue

5. SEX Male 6. RACE Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 8. DATE OF BIRTH JUNE 1942 9. AGE (In years last birthday) 25 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ROBERT RAGSDALE SR. 14. MOTHER'S MAIDEN NAME ADURY ROSE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 216-36-1105 17. INFORMANT DORA RAGSDALE 1204 E. LA FAYETTE ADDRESS

18. CAUSE OF DEATH E936.3 + 322.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Decapitation DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute alcoholism

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) RAILROAD TRACK 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) John Street Opening - Penna. Railroad

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 6 10 '67 ? m. 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] 21F. HOW DID INJURY OCCUR? Found on railroad track - decapitated

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE [Signature] M.D. CHIEF MEDICAL EXAMINER [X] DATE SIGNED 6-10-67 EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. ASSISTANT MEDICAL EXAMINER [ ] ASSOCIATE MEDICAL EXAMINER [ ]

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23B. DATE 7-6-67 23C. NAME OF CEMETERY or CREMATORY MT AUBURN 23D. LOCATION (City, town, or county) (State) BALTIMORE MD

24A. DATE REC'D BY HEALTH DEPT. JUL 6 1967 24B. NAME OF REGISTRAR [Signature] 24C. FUNERAL DIRECTOR JOSEPH KNIGHT 1639 N. BROADWAY ADDRESS

N874.2

WALLACE GOING

WALLACE GOING

WALLACE GOING

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-12968 67 6441		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6441	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BABY BOY HARN (DUANE W. E.)</b>		2. DATE AND HOUR OF DEATH <b>7-3-67 4:05 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY HOSP.</b>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <b>6815 EVERALL AVE.</b>	
5. SEX <b>M</b>	6. RACE <b>W W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>CHILD.</b>	8. DATE OF BIRTH <b>6-28-67</b>	9. AGE (In years last birthday) <b>5 DAYS</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CLIFFORD E. HARN</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET L. THOMAS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Clifford E. Harn - 6815 Everall Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CHF</b> DUE TO <b>congenital Heart Disease</b> <b>Single Chamber heart</b> DUE TO <b>truncus arteriosus</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>18 hour</b> <b>4 days</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 28 19 67</b> to <b>July 3 19 67</b> , that (I) (we) last saw the deceased alive on <b>July 3 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE <b>William E. Latimer MD</b>		23B. DATE SIGNED <b>4 July '67</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.		23E. FUNERAL DIRECTOR <b>Spangler Miller - 2334 Jefferson St.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7-6-67</b>		24C. NAME of CEMETERY or CREMATORY <b>OAK LAWN CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO., Mo.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	

July 30 1903

July 30 1903

July 30 1903



BIRTH NO. 67 6442

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 6442

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MICHAEL F. SCHMIDT

2. DATE AND HOUR PRONOUNCED DEAD

July 1, 1967

3:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

218 North Madeira Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

218 North Madeira Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

Aug. 11 - 1906

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CHAFFEUR

10B. KIND OF BUSINESS OR INDUSTRY

TRUCKING

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN J. SCHMIDT

14. MOTHER'S MAIDEN NAME

ELIZABETH PREISINGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Catherine Schap - 531 N. Belvidere Ave.

18. 4-20-01

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 2, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

7-5-67

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cem.

23D. LOCATION

(City, town, or county)

(State)

BALTO., Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 6 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Huntley Miller 2334 Jefferson St

1941

Nov 11-1941

MARKING

EUROPEAN DISTRICT

10-11-1941

1941

MARKING

EUROPEAN DISTRICT

10-11-1941

1941

10-11-1941

R-560

67 6443

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 6443

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MAE L. RENNER

2. DATE AND HOUR OF DEATH

6 AM 7/1/67

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

37

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3217 CHESTERFIELD

26-03

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

8-15-1901

9. AGE (In years  
last birthday)

65

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOMEMAKER

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WM. J. BUTZ

14. MOTHER'S MAIDEN NAME

MARGARET SAXTON

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mr. Howard L. Renner - 3217 Chesterfield Ave.

ADDRESS

18. 593X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Uremia

several wks.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) DUE TO

Exact nature of renal disease  
unknown R/O Lupus nephritis  
R/O Chronic glomerulonephritis

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0 None

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-26 1967 to 7-1 1967,  
that (I) (we) last saw the deceased alive on 6-30 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E Lee Robbins

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

7-1-67

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

M.D.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

7-5-67

24C. NAME of CEMETERY or CREMATORY

OAK LAWN CEMETERY

24D. LOCATION

BALTO., Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 6 1967 Robert E. Fink, M.D.

Hester Hill - 2334 Jefferson St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Urethane

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6444				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6444	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>OATES WESLEY VERNON</b>		2. DATE AND HOUR OF DEATH <b>June 30th 1967 1140 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b>		B. COUNTY <b>Balto. Co.</b>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Pikesville</b>				D. STREET ADDRESS (If rural, give location) <b>12 Brightside Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>Married</b>	8. DATE OF BIRTH <b>04-05-92</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Tovell Const. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>Edgar Oates</b>				14. MOTHER'S MAIDEN NAME <b>Etta Gup-ton</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-03-3802</b>		17. INFORMANT <b>Mrs. Anna M. Oates</b>		ADDRESS <b>12 Brightside Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>MYOCARDIAL INFARCTION</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6-25 1967</b> to <b>6-30 1967</b> , that (I) (we) lost saw the deceased alive on <b>6-30 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Fridtjofur Bjornsson</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-30 67</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRIDTJOFUR BJORNSSON</b> M.D.				23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 3, 1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Frank J. Newell</b>		ADDRESS <b>Pikesville, Md.</b>	

1891

1892

1893

1894

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6445		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 6445	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Reed Carroll</b>		2. DATE AND HOUR OF DEATH <b>June 29/67</b> 10 <sup>5</sup> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 Mid Town Nursing Home 808 Saint Paul Street Baltimore, Maryland 21202</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1929 West Baltimore St.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>4/28/1888</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter - Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>	
13. FATHER'S NAME <b>Carroll</b>		14. MOTHER'S MAIDEN NAME <b>Fannie</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-12-3564</b>		17. INFORMANT ADDRESS <b>Mrs. Helen Carroll same address</b>	
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <b>Cardio Respiratory Failure</b> DUE TO <b>Massive Cerebral Hemorrhage</b> (B) <b>Arteriosclerotic CVA</b> DUE TO <b>Diabetes Mellitus</b> (C) <b>CVA, old</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 9</b> 19 <b>64</b> to <b>June 29</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>June 29</b> 19 <b>67</b> and that in (my) <b>(my)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> (did not) view the body after death.					
23A. SIGNATURE <b>William D. Appleberry</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>6/30/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>William D. Appleberry</b>		23D. ADDRESS <b>5507 Park Heights Rd.</b>			
24A. BURIAL REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/3/1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Wm. F. Fisher &amp; Sons</b>			
25D. ADDRESS <b>Baltimore, Md.</b>					

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Handwritten notes, possibly a list or description, located in the lower left quadrant of the page.

Handwritten notes, possibly a list or description, located in the lower right quadrant of the page.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

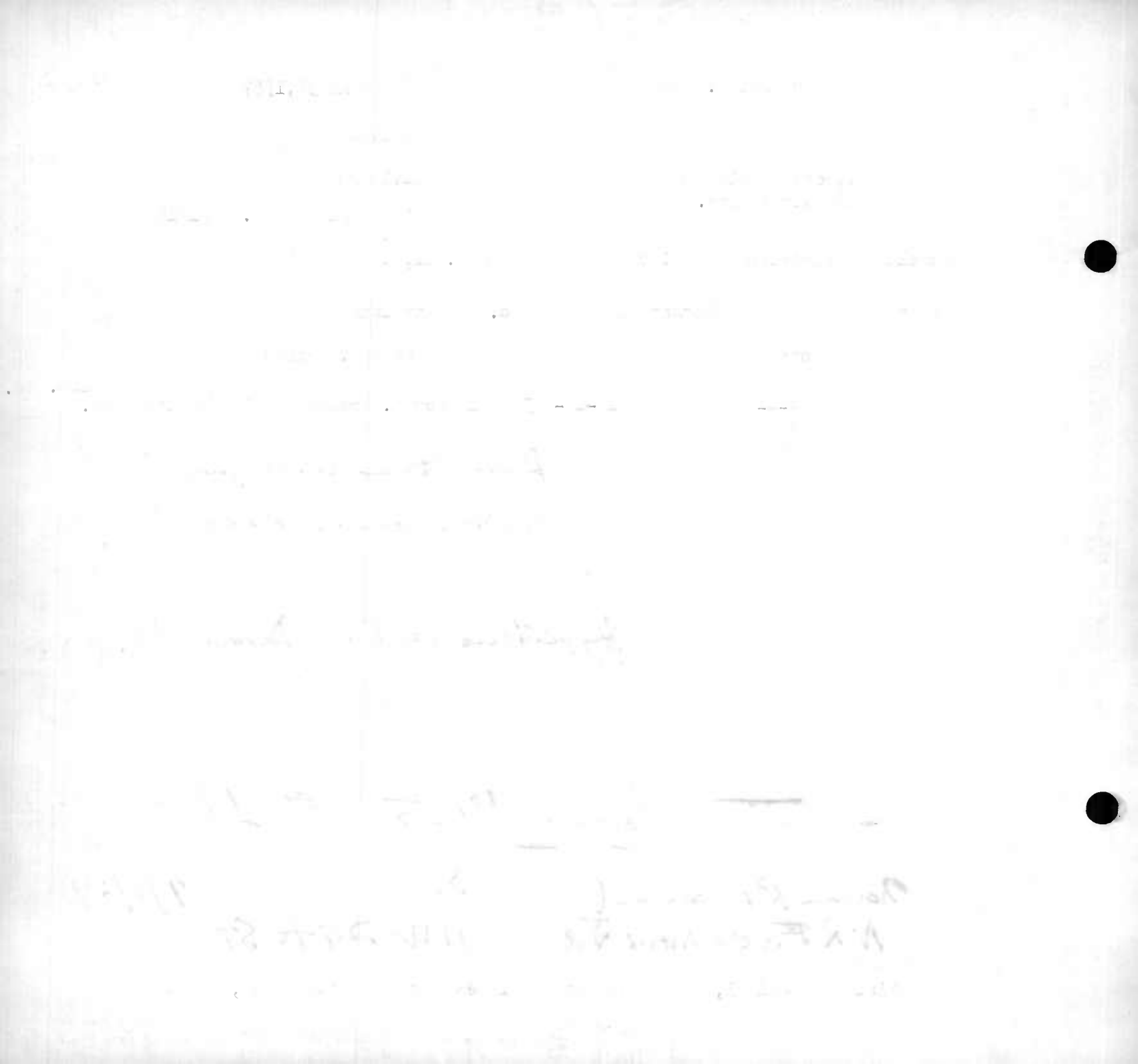
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6446</b>	
BIRTH NO. <b>67 6446</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <b>BRUCKER, MARGARET</b>		2. DATE AND HOUR OF DEATH <b>7-1-67 6<sup>55</sup>P.M.</b>	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21211</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>911 Keswick</b>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 13-07</b>	
				D. STREET ADDRESS (If rural, give location) <b>700 W. 40th St.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. <del>MARRIED, NEVER MARRIED</del> <b>WIDOWED, DIVORCED</b> (specify)	8. DATE OF BIRTH <b>11-21-1870</b>	9. AGE (In years last birthday) <b>96</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGRAVER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>John W. Brucker</b>			14. MOTHER'S MAIDEN NAME <b>Risilla Frances Leland</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-09-3209</b>		17. INFORMANT ADDRESS <b>Margaret P. Hurdle, 911 Keswick</b>	
18. <b>72211</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Cerebral thrombosis</b> DUE TO (B) <b>Arteriosclerotic CVA</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>? yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 14 1949</b> to <b>July 1st 1967</b> , that (I) (we) last saw the deceased alive on <b>1 Aug 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harold P. Biehl</b> M.D.				23B. DATE SIGNED <b>7-2-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>HAROLD P. BIEHL</b> M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/6/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore City</b>		24E. (State) <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Pickner &amp; Sons - North &amp; Pa. Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6447 CERTIFICATE OF DEATH					Registered No. 67 6447				
BIRTH NO. M.E. CASE NO.					1. NAME OF DECEASED				
(Type or Print)					Margaret M. Brandy				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
90 Melrose Nursing Home 115 Melrose Ave.					Maryland				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					2822 Maryland Ave. 21218				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
Female		Caucasian		Widowed		Aug. 11, 1884		82	
								If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Saleslady				Hochschild Kohn & Co.		Maryland			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
John Gross					Margaret France				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					215-10-9734		Eleanor F. Brandy 2822 Maryland Ave. Balto. Md.		
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
(A) Dissecting aneurysm 8 wks.									
(B) Arteriosclerosis 10 yrs.									
(C)									
INTERVAL BETWEEN ONSET AND DEATH									
11									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
Hypertensive C.V. Disease 10 yrs.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from 12/2-19 59 to 6/30-19 67, that (I) ( <del>we</del> ) last saw the deceased alive on 6/30-19 67 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE								23B. DATE SIGNED	
Norman R. Freeman M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>								7/1/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
N R Freeman Jr				11 W 29th St					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		July 3, 67		New Cathedral Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUL 6 1967		Robert E. Taylor, M.D.		Wm. J. Tickner & Sons		North & Pa Aves Balto Md #17			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

STEPHENS, JANE MARY 6.30.67

MD

The Union Monument Hotel Baltimore  
2924 St Paul St. Baltimore

~~188-84~~ 83

F W Wicks

USA

Virginia  
Ella Walker

Robert O. Halsey

I I Bleeding the  
to Hunter's

Capitulum Heart failure

6.30 8.30 6.30 6.30 6.30

6.30.67 X

Police I. Martin

THE UNION MONUMENT HOTEL

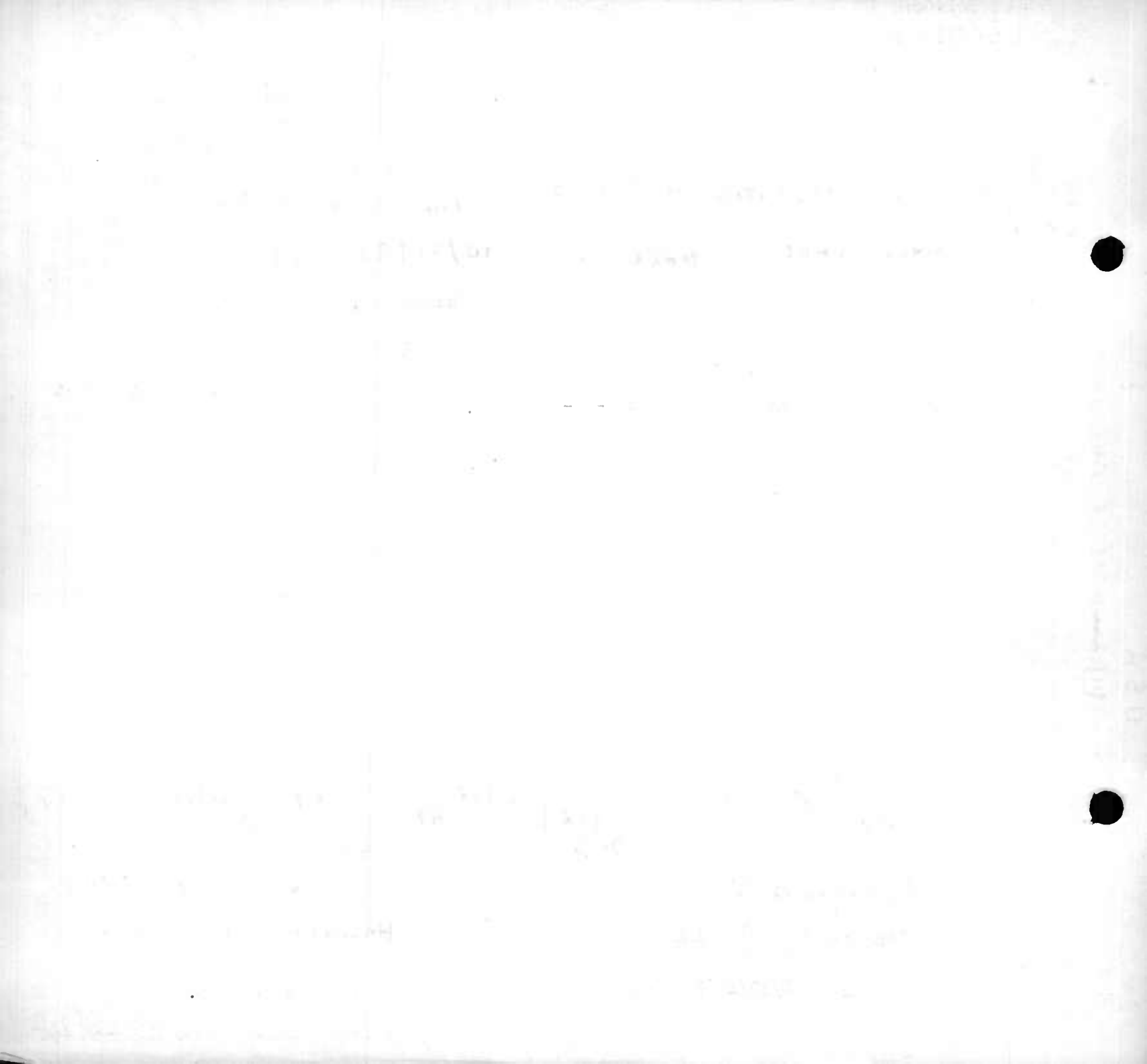
THE UNION MONUMENT HOTEL

THE UNION MONUMENT HOTEL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 6449 CERTIFICATE OF DEATH					Registered No. 67 6449					
BIRTH NO.					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Herbert Frantz</b>					2. DATE AND HOUR OF DEATH <b>JUNE 28, 1967 5<sup>23</sup> P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTO.</b>					A. STATE <b>MD.</b>					
(If not in hospital or institution, give street address or location)					B. COUNTY					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>					
					D. STREET ADDRESS (If rural, give location) <b>3140 KESWICK ROAD</b>					
5. SEX <b>MALE</b>		6. RACE <b>CAUC.</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>10/31/92</b>		9. AGE (In years lost birthday) <b>74</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Shenandoah, Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Frederick Frantz</b>					14. MOTHER'S MAIDEN NAME <b>Carrie Eisenhower</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>					16. SOCIAL SECURITY NO. <b>184-05-9064</b>		17. INFORMANT ADDRESS <b>200 Jardin Street</b>			
					<b>W. Harry Waters and Sons, Funeral Home</b>					
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b>					CAUSE OF DEATH (A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO					
					(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>6/28</b> 19 <b>67</b> to <b>6/28</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/28</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>Melvyn B. Lewis</b>								23B. DATE SIGNED <b>6/28/67</b>		
23C. PHYSICIAN'S NAME (Type) <b>MELVYN B. LEWIS</b>								23D. ADDRESS <b>SINAI HOSPITAL OF BALTO.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>6/30/1967</b>		24C. NAME of CEMETERY or CREMATORY <b>Odd Fellows Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Shenadoah, Penn.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>			25B. NAME OF REGISTRAR <b>Robert E. Fairley</b>			25C. FUNERAL DIRECTOR <b>Wm. Fickner Sons</b>			ADDRESS <b>Balto, Md</b>	





# FUNERAL DIRECTOR: IMPORTANT

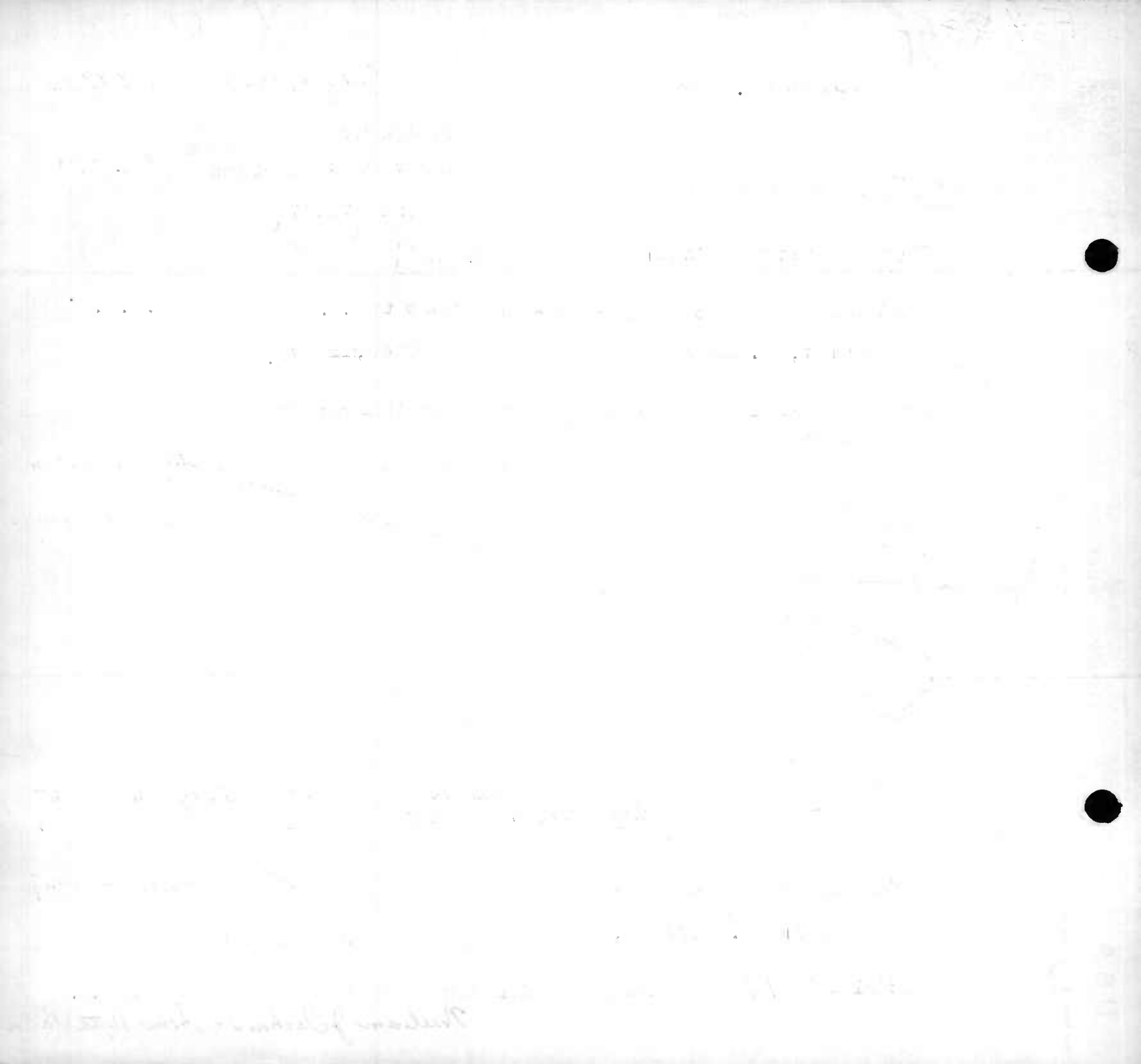
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6450	
BIRTH NO. 67 6450		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MICHAEL, MARY D.</b>		2. DATE AND HOUR OF DEATH <b>July 2, 1967 9:55 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 12-02</b>	
5. SEX <b>F</b>		6. RACE <b>W</b>		D. STREET ADDRESS (If rural, give location) <b>3231 St. Paul St. HOME</b>	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>11-14-90</b>		9. AGE (In years last birthday) <b>76</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JAMES DAWKINS</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELIZABETH DEMMING</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. MARY BRUMFIELD</b> ADDRESS <b>3231 ST. PAUL ST BALTO MARYLAND 21218</b>	
18. <b>351X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>CEREBRAL VASCULAR ACC</b> DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <b>(6/9/67) 23 days</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>ASCVD</b>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. MEDICAL CERTIFICATION			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/9/67</b> 19 to <b>7/2</b> 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>7/2</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Enrique Cipriani</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>7/2/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ENRIQUE CIPRIANI,</b>		M.D. <b>UNION MEMORIAL HOSP.</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/5/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION <b>Woodlawn, Md.</b>		24E. CITY, TOWN, or COUNTY <b>Woodlawn, Md.</b>		24F. STATE <b>Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wm. J. ...</b>	

ISEE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 6451		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6451	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Sanford C. Flint</i>		2. DATE AND HOUR OF DEATH <i>July 4, 1967</i>		<i>3:40 AM</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>NEW JERSEY</i> B. COUNTY <i>WESBURG PARK Interlaken</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <i>21 RONA STREET</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>9/27/98</i>	9. AGE (In years lost birthday) <i>68</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>President</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Monmouth Products Co</i>		11. BIRTHPLACE (State or foreign country) <i>Monmouth N.J.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>FLINT, H. SANFORD</i>			14. MOTHER'S MAIDEN NAME <i>CROWLEY, MARY J.</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World 1</i>		16. SOCIAL SECURITY NO. <i>142 07 6449</i>		17. INFORMANT <i>Hospital records</i>			ADDRESS
18. <i>204.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>pneumonia of several days duration prior to death</i> DUE TO (B) <i>Chronic monocytic leukemia sev. months</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>JUNE 26</i> 19 <i>67</i> to <i>JULY 4</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>230 JULY 4</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>David H. Huffman M.D.</i>				23B. DATE SIGNED <i>July 4, 1967</i>			
23C. PHYSICIAN'S NAME (Type) <i>DAVID H. HUFFMAN,</i>				23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1967 7/7/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Monmouth Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>New Shrewsbury Township N.J.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 6 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>William J. Zickner + Son North + Palen</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6452				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6452	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Jemima Truitt		July 1, 1967 12:01 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
Bolton Hill Nursing Home				A. STATE Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
90				Baltimore 11-03			
5. SEX Female				6. RACE Caucasian			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				8. DATE OF BIRTH June 16, 1995			
9. AGE (In years lost birthday) 72				10. BIRTHPLACE (State or foreign country) Maryland			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles C. Ridgely				14. MOTHER'S MAIDEN NAME Rachel Maynard			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220 05 5772A			
17. INFORMANT ADDRESS				Records: Bolton Hill Nursing Home			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Arteriosclerotic Cardio-Vascular Disease 10 yrs			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(B) Parkinson's Disease 12 yrs			
ANTECEDENT CAUSES				(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			
(APPROX.)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (We) attended the deceased from May 1st 19 to July 1st 1967, that (I) (We) last saw the deceased alive on June 30th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Philip D. Flynn				23B. DATE SIGNED 7-1-67			
23C. PHYSICIAN'S NAME (Type) Philip D. Flynn				23D. ADDRESS 11 E. Chase St. Baltimore Md. 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE July 5, 67			
24C. NAME OF CEMETERY or CREMATORY Mount Olivet Cemetery				24D. LOCATION Frederick Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1967				25B. NAME OF REGISTRAR Robert E. Farley, MA			
25C. FUNERAL DIRECTOR Wm. J. Tickner & Sons				ADDRESS North 9th Ave. Balto., Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 6453		67 6453		67 6453	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
CHADWICK, WILLIAM JOHN			7/3/67 13 <sup>15</sup> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
UNION MEMORIAL HOSPITAL BALTIMORE, MARYLAND			MARYLAND		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			802 EXETER HALL AVE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
M	W	M	03-11-93	74	U. S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
RETIRED			MARYLAND		U. S.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
GEORGE W. CHADWICK			SARAH L. BARGER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
			MRS. MINNIE CHADWICK (SAME)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
420.1x141.9			ACUTE MYOCARDIAL INFARCT 4 DAYS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Ca THORACIC (RESECTED)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/30 19 67 to 7/3/ 19 67, that (I) (we) lost saw the deceased alive on 7/3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Charles S. Brown				7/3/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
CHARLES S. BROWN, M.D.				UNION MEMORIAL HOSPITAL BALTIMORE, MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7/6/67		Abe	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 6 1967		Robert E. Tarkenton		William J. Lickner + Sons North + Palms	





MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 6454**

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SPENCER ANDERSON

2. DATE AND HOUR PRONOUNCED DEAD

July 1, 1967

7:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

100 1070 West Fayette Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1070 West Fayette Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

7-3-02

9. AGE (In years  
lost birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Carpenter

11. BIRTHPLACE (State or foreign country)

Albany, Georgia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Spencer Anderson

14. MOTHER'S MAIDEN NAME

Mary Maddox

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Annie Hurt 1823 N. Caroline St. 21213

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A)  
DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 2, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-7-1967

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Marshall W. Jones, Jr. 1735 Harford Ave.  
21213

JUL 6 1967

U.S.A.

Albany, Georgia

7-1-02

Midwest

Lawrence

Laboret

Spencer Anderson

Mary Nathan

no

Mrs. Anna Ruth 1803 S. Carolina St. (1911)

Baltimore, Maryland

Mr. Arthur Comstock

7-5-1907

Bureau

Marshall W. Jones, Jr. 1725 Madison Ave.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6455</b>	
BIRTH NO. <b>67 6455</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Beiersdorfer Max</b>		2. DATE AND HOUR OF DEATH <b>6/30/67 4 A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>			
<b>48 Maryland General Hos.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 27-07</b>			
		D. STREET ADDRESS (If rural, give location) <b>2818 Clearview Ave</b>			
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3/30/02</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hopcor inc</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Reinhold Beiersdorfer</b>			
14. MOTHER'S MAIDEN NAME <b>Bentha Loehyel</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-34-8440</b>	
17. INFORMANT <b>Patient</b>		ADDRESS <b>See Above</b>			
18. <b>4201 I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>Myocardial Infarction under 24 hrs</b>			
ANTECEDENT CAUSES		(B) DUE TO <b>ASCVD</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>Pulmonary edema</b>			
II		Operation - femoral endarterectomy + saphenous vein graft to superficial femoral, 3 carcinomas of lung			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION <b>6/25/67</b>			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>occluded (L) femoral artery</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/24</b> 19 <b>67</b> to <b>6/29</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/28</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>B. Ann Ward</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/30/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>B Ann Ward</b>		23D. ADDRESS <b>MD Gen. Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7-3-67</b>		24C. NAME of CEMETERY or CREMATORY <b>St. John Lutheran</b>	
24D. LOCATION (City, town, or county) (State) <b>Parkville Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>			
25B. NAME OF REGISTRAR <b>R. D. E. Farber</b>		25C. FUNERAL DIRECTOR <b>C. F. Evans</b>		ADDRESS <b>8802 Hartford Rd.</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 6456	
BIRTH NO. 67 6456		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JOHNSON, EMMA H.</u>		2. DATE AND HOUR OF DEATH <u>7/2/67 8:45 AM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSPITAL</u> <u>33 BALTO, MD 21205</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>Harford Co.</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>CHURCHVILLE, MD. 21028</u> <u>162-00</u>			
		D. STREET ADDRESS (If rural, give location) <u>RT. 1 BOX 360</u>			
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-25-1917</u>	9. AGE (In years lost birthday) <u>49</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Harford County School Board</u>		11. BIRTHPLACE (State or foreign country) <u>Versailles, Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>EDGAR D. HALL</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MAE CLOUDERS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-26-2553</u>		17. INFORMANT <u>Mrs. Carol Annamae Johnson</u> ADDRESS <u>Rt. #1 Box 360 Churchville, Md. 21028</u>	
18. <u>200.0 I</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.)		(A) <u>RETICULUM CELL SARCOMA</u> DUE TO		<u>8 MONTHS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg; etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>6/26</u> 19 <u>67</u> to <u>7/2</u> 19 <u>67</u> , that (2) (we) lost saw the deceased alive on <u>7/2</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John T. Flaherty</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7/2/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN T. FLAHERTY</u>		23D. ADDRESS <u>1505 E. MONUMENT ST. BALTIMORE, MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-6-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Asbury Methodist Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Churchville, Harford Co. Md.</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>JUL 6 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Otelia J. Bullock</u>		ADDRESS <u>Harve de Grace Md 21078</u>			

Barth, Mr. 2121

Widowed

Edgar, J. Hall  
And the Chicago

2121-2122 New York Avenue

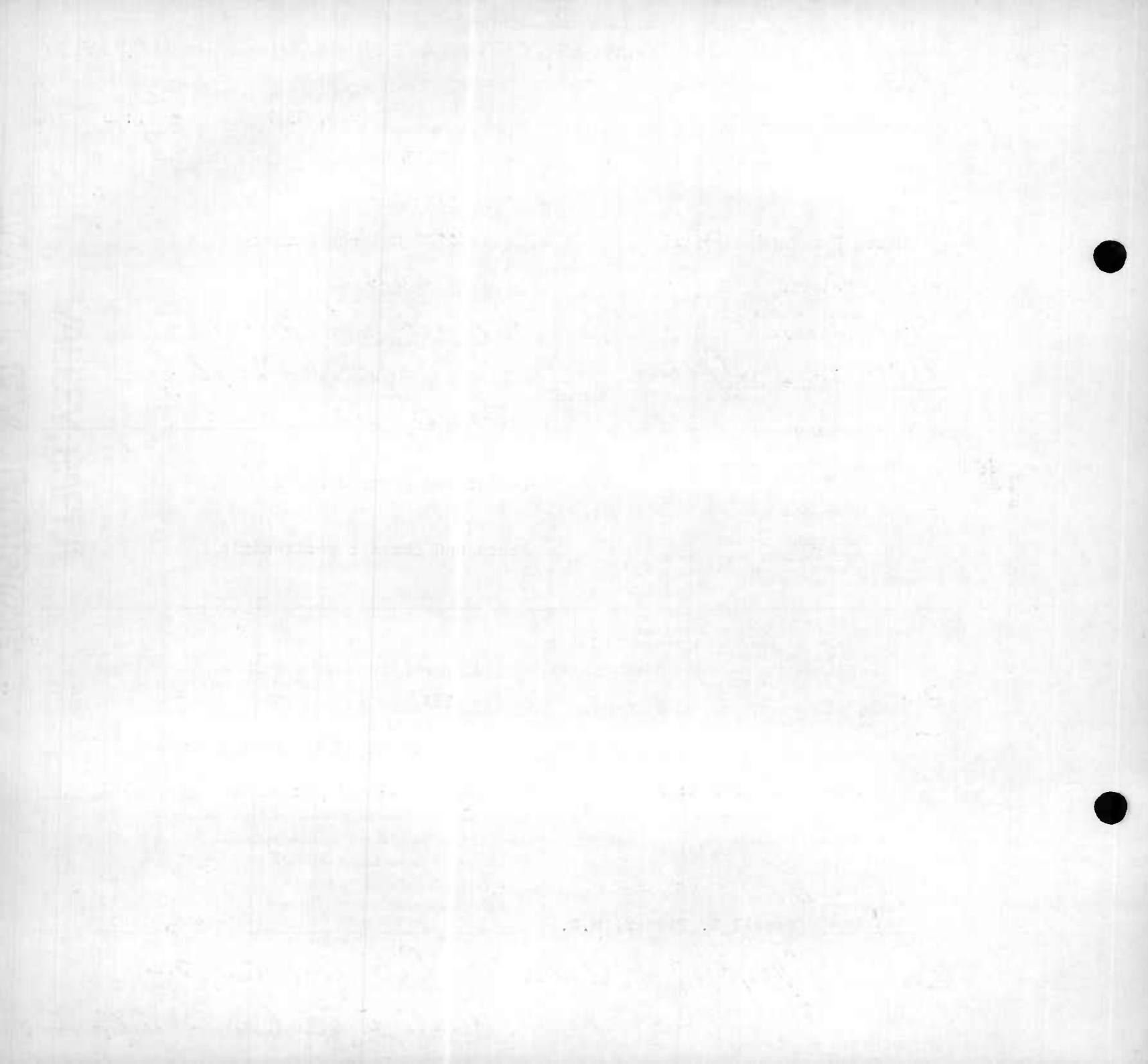
129

5-152

## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 6457 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6457  
M.E. CASE NO. 67 6457

1. NAME OF DECEASED (Type or Print) <b>AUBREY SPENCER</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>July 4, 1967</b>   <b>9:45 p.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Church Home and Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>6-03</b> D. STREET ADDRESS (If rural, give location) <b>2208 Orleans Street</b>	
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>Jan. 22/1929</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Norman Spencer</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Sterling</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Emily Spencer</b>		ADDRESS	
18. <b>E981X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Perforated gastric ulcer</b> DUE TO (A) <b>Perforated gastric ulcer</b> DUE TO (B) <b>Acute and chronic peritonitis</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Front of 400 Madera Street</b>		<b>6-03</b>	
21D. TIME OF INJURY (APPROX.) <b>June 11 1967 1:35 AM</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <b>During altercation Gunshot wound</b>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>July 8/67</b>	
23C. NAME OF CEMETERY or CREMATORY <b>Arbutus Men Park</b>		23D. LOCATION (City, town, or county) (State) <b>Arbutus, Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Fardina</b>	
24C. FUNERAL DIRECTOR <b>Wilton E. Edwards</b>		24D. ADDRESS <b>1129 N. Carroll</b>	





FUNERAL DIRECTOR: IMPORTANT

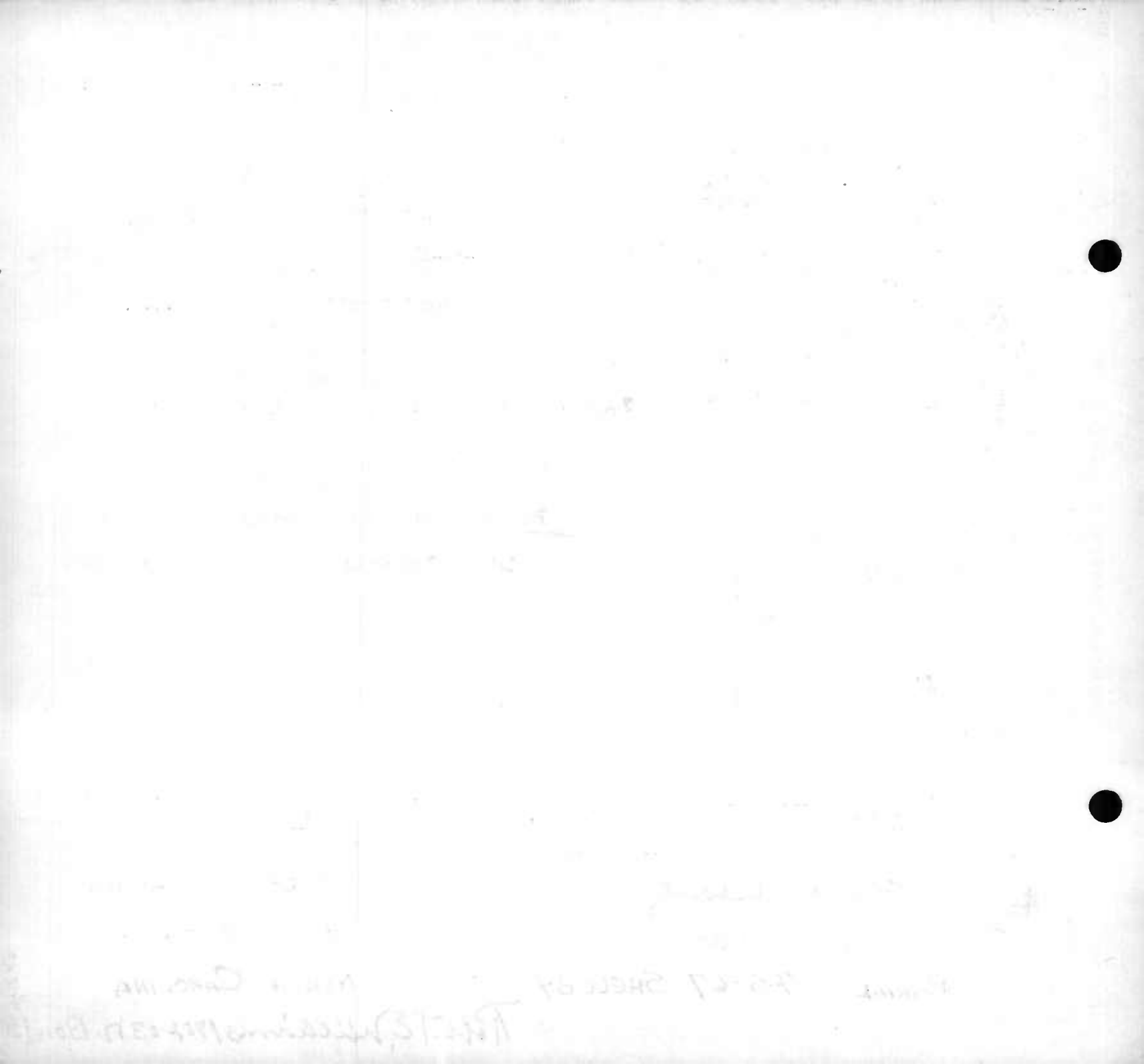
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6458</b>	
BIRTH NO. <b>67 6458</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BENJAMIN STEWART</b>		2. DATE AND HOUR OF DEATH <b>7/2/67 6:05 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSP.</b>		A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>2101 W. COLDSRING LANE</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>—</b>	8. DATE OF BIRTH <b>7-3-87</b>	9. AGE (In years lost birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardener</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>La Plata Maryland</b>	
13. FATHER'S NAME <b>Fred Stewart</b>		14. MOTHER'S MAIDEN NAME <b>—</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-30-3460-A</b>		17. INFORMANT ADDRESS <b>HOSPITAL CHART</b>	
18. <b>199.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>OCCULT MALIGNANCY</b> DUE TO (B) <b>—</b> DUE TO (C) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>—</b>					
19A. DATE OF OPERATION <b>5-23-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>—</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) <b>this hospital</b> attended the deceased from <b>5-23-67</b> to <b>7-2-67</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>7-1-67</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Alvin Schachter</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>7-2-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALVIN SCHACHTER</b>		23D. ADDRESS <b>SINAI HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-7-67</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles R. Law, 802 Madison Ave.</b>	



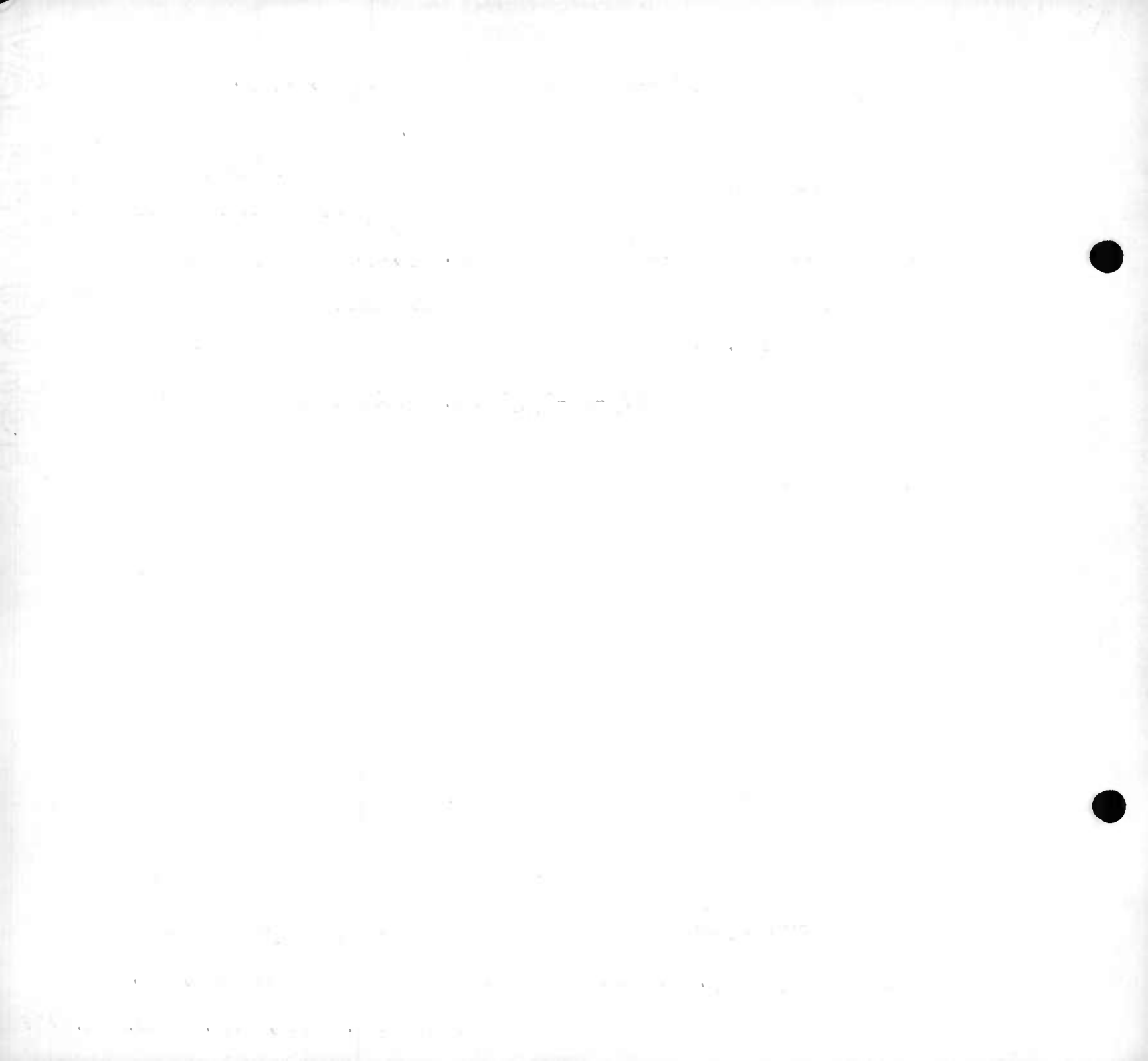
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6459				Baltimore City Health Department		Registered No. 67 6459	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>ERVIN BOYKIN</b>		2. DATE AND HOUR OF DEATH <b>7/2/67 7-2-67 1330 3:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>810 Rutland Avenue #21205</b>							
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-11-21</b>	9. AGE (In years lost birthday) <b>46</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Buck (Deceased)</b>			14. MOTHER'S MAIDEN NAME <b>Mattie (Deceased)</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>241-28-7289</b>		17. INFORMANT ADDRESS <b>BCH 4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>422.21</b> <b>MYOCARDIAL DISEASE; ?</b> <b>ETIOLOGY</b> <b>RETICULUM CELL SARCOMA</b> <b>SCLERODERMA</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>1 yr</b> <b>6 mos</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>May 9,</b> 19 <b>67</b> to <b>July 2,</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>July 2,</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Stewart Leibowitz</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>7/2/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Stewart Leibowitz</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Md. #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7-5-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>SHELLBY</b>		24D. LOCATION (City, town, or county) (State) <b>NORTH CAROLINA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Williams</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Robert E. Williams 1704-03 N. Bond</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6460</b>	
67 6460				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>James Edward Brady</b>			2. DATE AND HOUR OF DEATH <b>July 4, 1967. 6 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE <b>Md.</b>		
(If not in hospital or institution, give street address or location) <b>00 3218 Woodhome Avenue</b>			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 27-05</b>		
			D. STREET ADDRESS (If rural, give location) <b>3218 Woodhome Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 25, 1910</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James H. Brady</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wilhide</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-01-2935</b>		17. INFORMANT <b>Mrs. Marie Brady</b>	
18. <b>161 X I</b>		CAUSE OF DEATH		ADDRESS <b>(Same)</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>General Curmuckin</b>		INTERVAL BETWEEN ONSET AND DEATH <b>app 6 mm</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>hanged Curmuckin</b>		<b>app 18 mm</b>	
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5 July 1967</b> to <b>4 July 1967</b> , that (I) (we) last saw the deceased alive on <b>2 July 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Howard Goodman</b>				23B. DATE SIGNED <b>5 July 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Howard Goodman</b>				23D. ADDRESS <b>8604 Harford Road</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/7/67.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Trinity Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6461				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6461	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>DIGNAZIO, JOHN JOSEPH</b>				2. DATE AND HOUR OF DEATH <b>July 2, 1967 8:00 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 12-06</b> D. STREET ADDRESS (If rural, give location) <b>2436 SAINT PAUL STREET</b>			
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>08-17-67</b>		9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>TAVERN OWNER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>ANGELO DIGNAZIO</b>				14. MOTHER'S MAIDEN NAME <b>RACHEL AMATO</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO. <b>218-05-0510</b>		17. INFORMANT <b>MR. JOSEPH DIGNAZIO</b>		ADDRESS <b>5611 MAYVIEW AV. BALTO, MD.</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Cerebral Vascular accident</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July, Second 1967</b> to <b>July, Second 1967</b> , that (I) (we) last saw the deceased alive on <b>July 2nd 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Manuel Sanchez Palacios</b>				M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>July 2nd 1967</b>	
23C. PHYSICIAN'S NAME (Print) <b>MANUEL SANCHEZ PALACIOS</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/8/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Balto. Md. 21214</b>	

THE UNIVERSITY OF CHICAGO

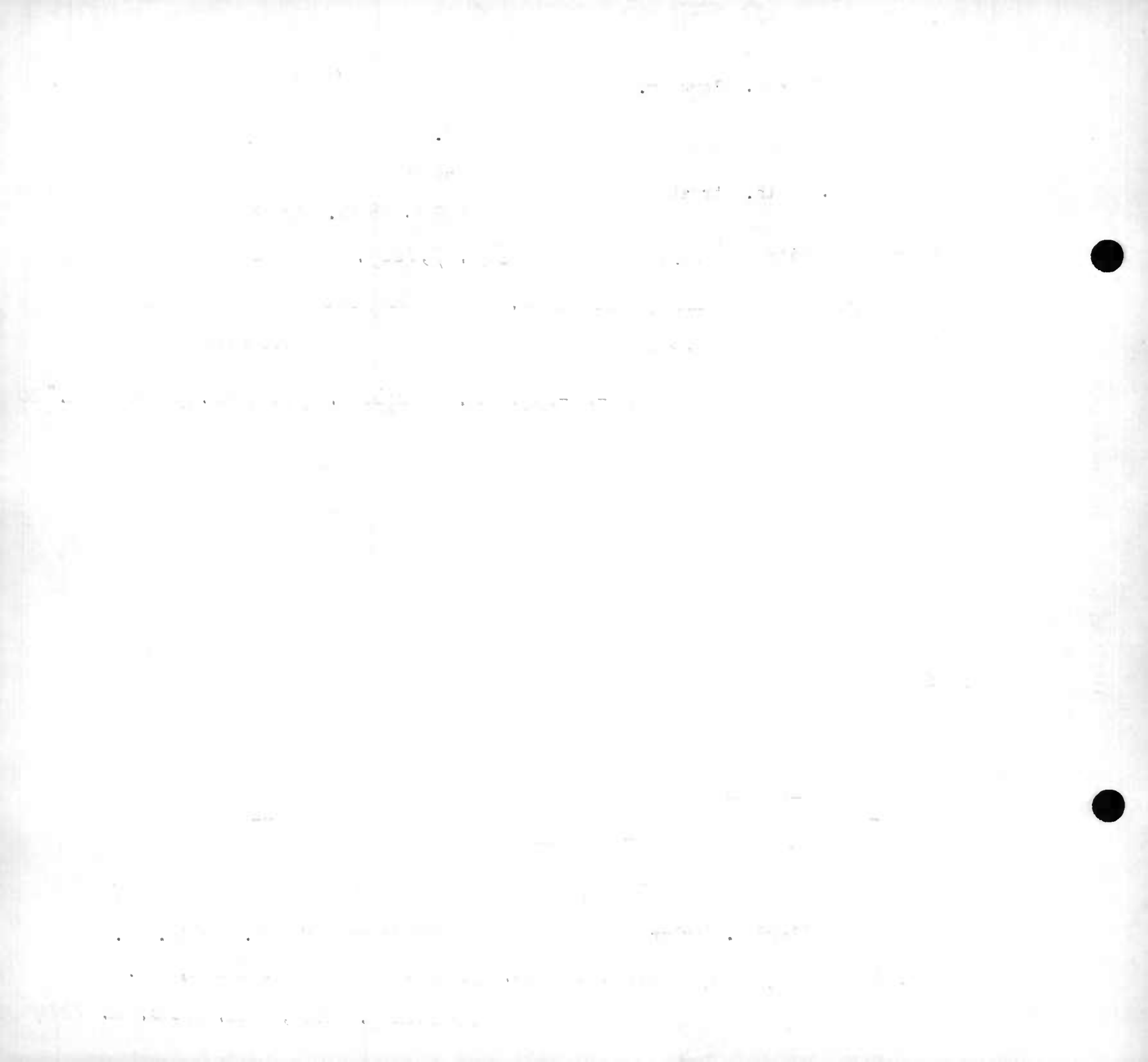
PHYSICS DEPARTMENT



# FUNERAL DIRECTOR: IMPORTANT

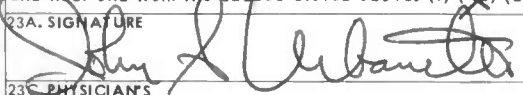
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6462				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6462	
1. NAME OF DECEASED (Type or Print) <b>Calvin J. Clark Sr.</b>				2. DATE AND HOUR OF DEATH <b>7/6/67 8:00 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 629 E. 38 th. Street</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>9-01</b> D. STREET ADDRESS (If rural, give location) <b>629 E. 38 th. Street</b>			
5. SEX <b>male/</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb. 7, 1883.</b>	9. AGE (In years lost birthday) <b>84</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Oles Envelope Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>? Clark</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>216-10-0541</b>		17. INFORMANT ADDRESS <b>Mr. Calvin J. Clark Jr. 473 Burke Rd. #20</b>		
18. <b>350X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Parkinson's syndrome</b> (A) DUE TO <b>15 yrs.</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic cardiovascular disease</b> (B) DUE TO <b>20 yrs.</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 19 57</b> to <b>July 6 19 67</b> , that (I) (we) lost saw the deceased alive on <b>June 21, 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Lloyd E. Saylor</b> M.D.						23B. DATE SIGNED <b>July 6, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lloyd E. Saylor</b>		23D. ADDRESS <b>3902 Greenmount Ave. Balto. Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/8/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Mem. Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 8 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6463		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6463	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>		DATE AND HOUR OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BURKE JOSEPH E.</b>		2. DATE AND HOUR OF DEATH <b>7/6/67 10:25 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balt.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>3132 Cliffmont Ave.</b>		8-01	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3/21/1899</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas station attendant</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Burke</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-03-6301</b>		17. INFORMANT <b>Mrs. Margaret Burke same</b>	
18. <b>330X I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Intercerebral Hemorrhage</b>		<b>about 14 hr.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 05 1967</b> to <b>July 06 1967</b> , that (I) (we) lost saw the deceased alive on <b>July 06 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>7/6/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN S. URBANETTI</b>		23D. ADDRESS M.D. <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/8/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">67 6464</span>	
BIRTH NO. <span style="font-size: 1.2em;">67 6464</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Charles O. Darney</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">4:05 7/6/67. 4:05 A</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.5em;">37</span> <span style="font-size: 1.2em;">Mercy Hospital</span>		A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore 21214</span>			
		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">2712 Strathmore Avenue</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED <span style="font-size: 1.2em;">WIDOWED, DIVORCED</span> (specify)	8. DATE OF BIRTH <span style="font-size: 1.2em;">March 7, 1893.</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">74</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired Contractor</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Fred Darney</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">? Kerr</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-07-3462</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. Ed. Darney, Lutherville, Md.</span>	
18. <span style="font-size: 1.2em;">451X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <span style="font-size: 1.2em;">Rupture of aneurysm of descending thoracic aorta</span> (A) DUE TO (B) DUE TO (C) <span style="font-size: 1.2em;">Severe ASCVD</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">minutes</span>   <span style="font-size: 1.2em;">yrs.</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.2em;">Congestive heart failure, salmonella enteritidis septicemia, left pleural effusion, old myocardial infarction</span>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">June 2</span> 19 <span style="font-size: 1.2em;">67</span> to <span style="font-size: 1.2em;">July 6</span> 19 <span style="font-size: 1.2em;">67</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">July 6</span> 19 <span style="font-size: 1.2em;">67</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (No) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Louis E. Grenzer</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">7/6/67</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Louis E. Grenzer</span>				23D. ADDRESS <span style="font-size: 1.2em;">Mercy Hospital</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">7/10/67</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Moreland Mem. Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUL 6 1967</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farley, Md</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Leonard J. Ruck, Inc. Balto. Md. 21214</span>	

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BIRTH NO. 67 6465 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6465  
 M.E. CASE NO. 67-05168

1. NAME OF DECEASED (Type or Print) <b>GEORGE STILLINGS</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>July 2, 1967</b>   <b>1:15 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33</b> <b>99</b> <b>JOHNS HOPKINS HOSPITAL D.O.A.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2406 E. Fayette Street</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>March 16, 1967</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>3 Mo.</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Finecey</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Stilling</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mildred Stilling 2406 E. Fayette St.</b>

MEDICAL CERTIFICATION	18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>795.21</b> (A) DUE TO <b>(SDII)</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH		
	19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
	21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
	21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
	22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
	ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>July 3, 1967</b>		
	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
	23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>7-5-1967</b>	23C. NAME of CEMETERY or CREMATORY <b>Glen Haven</b>	23D. LOCATION (City, town, or county) (State) <b>Anne Arundel, Maryland</b>
	24A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	24C. FUNERAL DIRECTOR ADDRESS <b>Lilly &amp; Zeiler Inc. 1901 Eastern Ave.</b>	

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6486		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6486	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNIE SHULKA		2. DATE AND HOUR OF DEATH JULY 4, 1967 12 NOON	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 11-03 D. STREET ADDRESS (If rural, give location) 841 N. Eutaw			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5/27/97	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Austria 7	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alexander Kozub		14. MOTHER'S MAIDEN NAME Mary Skowronek	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-6788		17. INFORMANT ADDRESS Theodore Shulka 841 N. Eutaw Street	
18. 4201 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Acute Myocardial Infarction (B) DUE TO ASCVD (C) _____		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/30 1967 to 7/4 1967, that (I) (we) lost saw the deceased alive on 7/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE Donald H. Dembo		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/4/67	
23C. PHYSICIAN'S NAME (Type) DONALD H. DEMBO		23D. ADDRESS 827 LINDEN AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-1967		24C. NAME OF CEMETERY or CREMATORY St. Michael	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.			

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 6467		Baltimore City Health Department		Registered No. 67 6467	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MARGARET M. YEAGER Yeager		7/4/67		14:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
THE JOHNS HOPKINS HOSP 33		MARGARET MARYLAND		Balt Co	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		53-00	
1. SEX		2. RACE		3. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
FEMALE		WHITE		WIDOWED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Baltimore, Maryland.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Nicholas Ellinghaus		Margaret O'Leary		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		215-40-7582		Elizabeth Allman 1619 French Ave Balto 21,	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		1 1/2 MONTH	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		NONE			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/27 1967 to 7/4 1967, that (I) (we) last saw the deceased alive on 7/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Harry K. Genant				7-4-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Harry K. Genant		The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		July 7 67		Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
5501 Frederick Road Balto, Md		JUL 6 1967		Robert E. Farley	
24G. FUNERAL DIRECTOR		24H. ADDRESS			
The Dippel Inc 1800 E Lombard Street					

MARGARET MARYLAND

BALTIMORE

1760 BROOKVIEW ROAD

11-5-18

FEMALE WHITE WIDOWED

Housewife

Nicholas Kiliaghas

Margaret O'Leary

215-40-7282 Elizabeth Wilman 1619 French Ave Balto Md

HARRINGTON & TO PROVE

STANDARD CELL

1/2 MONTH

None

Harvey & Bennett

1/17

1/17

1/17

1-11-17

X

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 6468</span>	
BIRTH NO. <span style="float: right;">67 6468</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Maud Loretta Pratt (Maude)</u>			July 1, 1967 9:05 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>1503 W. Fairmount Avenue Baltimore, Maryland</u>			A. STATE <u>Maryland</u>		
			C. CITY OR TOWN (If outside city limits, write FULL and give township) <u>Baltimore</u>		
100			D. STREET ADDRESS (If rural, give location) <u>1503 W. Fairmount Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 7, 1898</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Simmons</u>			14. MOTHER'S MAIDEN NAME <u>Cora Mackle</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Florence King 1503 W. Fairmount Ave</u>
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Myocardial infarction</u> DUE TO (B) <u>Arteriosclerotic Cardio Vascular disease</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>July, 1967</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1967</u> to <u>June 21, 1967</u> , that (I) (we) lost saw the deceased alive on <u>June 21, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Royston B. Scott</u> M.D.				23B. DATE SIGNED <u>July 3, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROYSTON B. SCOTT</u> M.D.				23D. ADDRESS <u>1801 W BALTIMORE ST. BALTIMORE, MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-5-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. FUNERAL DIRECTOR ADDRESS <u>Arlington S. Phillips 1727 N. Monroe Street</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips 1727 N. Monroe Street</u>	



1  
D-620

67 6469

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6469

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MILTON DORSEY

2. DATE AND HOUR PRONOUNCED DEAD

July 1, 1967

7:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00

1521 Poplar Grove Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1521 Poplar Grove Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

April 29, 1917

9. AGE (In years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Dental Sec.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Charles Dorsey

14. MOTHER'S MAIDEN NAME

Emma Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

216-01-3772

17. INFORMANT

Ruth Dorsey

ADDRESS

Same

18.

150X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinoma of esophagus with metastases  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 1, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7/6/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 6 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Arlington Phillips 1727 N. Mount St.

ADDRESS

—X—

THE UNIVERSITY OF

CHICAGO

LIBRARY



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6470					Registered No. 67 6470				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>MAUD MAX SCHLEIN</b>					2. DATE AND HOUR OF DEATH <b>JULY 3, 1967 1:35 A. M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto. Co</b>				
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST. AGNES HOSPITAL WILKENS &amp; CATON AVES. BALTIMORE, MD. #29</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>				
					D. STREET ADDRESS (If rural, give location) <b>4304 ALAN DRIVE Apt. B.</b>				
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>		8. DATE OF BIRTH <b>1-17-95</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>ROBERT WARFIELD</b>				14. MOTHER'S MAIDEN NAME <b>LAURA APPLEBY</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL WILKENS &amp; CATON</b>			
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>C.V.A.</b>				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Diabetes Mellitus</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS CONTRIBUTING OR CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>6-22-67</b> 19 <b>67</b> to <b>JULY 3</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>JULY 3</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Federico Pollicina</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>FEDERICO POLLICINA</b>				23D. ADDRESS <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AV</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/6/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. 21229</b>			

1555

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.5em;">67 6471</span>	
BIRTH NO. <span style="font-size: 1.2em;">67-14043 67 6471</span>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <b>FOX, BABY BOY Dale Michael</b>				2. DATE AND HOUR OF DEATH <b>JULY 3, 1967</b>		5:20A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 2em;">40</span> <b>ST. AGNES HOSPITAL</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY <span style="font-size: 1.2em;">Balto. Co</span>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE, MARYLAND 21227</b> <span style="font-size: 1.2em;">53-00</span>			
				D. STREET ADDRESS (If rural, give location) <b>5512 THOMAS AVE.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEW BORN</b>	8. DATE OF BIRTH <b>7/2/67</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEW BORN</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOSEPH FOX</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN FREY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NONE</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL</b>		
18. <span style="font-size: 1.2em;">762.51</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b>  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Probable Pulmonary Atelectasis</i> DUE TO (B) <i>Low Birth Weight</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>JULY 2,</u> 19 <u>67</u> to <u>JULY 3</u> 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>JULY 3</u> 19 <u>67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">XXXXXXENXXXXX</span> <i>Joseph M. Boyd</i> M.D.						23B. DATE SIGNED <span style="font-size: 1.2em;">7-3-67</span>	
23C. PHYSICIAN'S NAME (Type) <b>JOYCE M. BOYD</b> M.D.						23D. ADDRESS <b>ST. AGNES HOSP; CATON &amp; WILKENS AVES.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-6-1967</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUL 6 1967</span>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			

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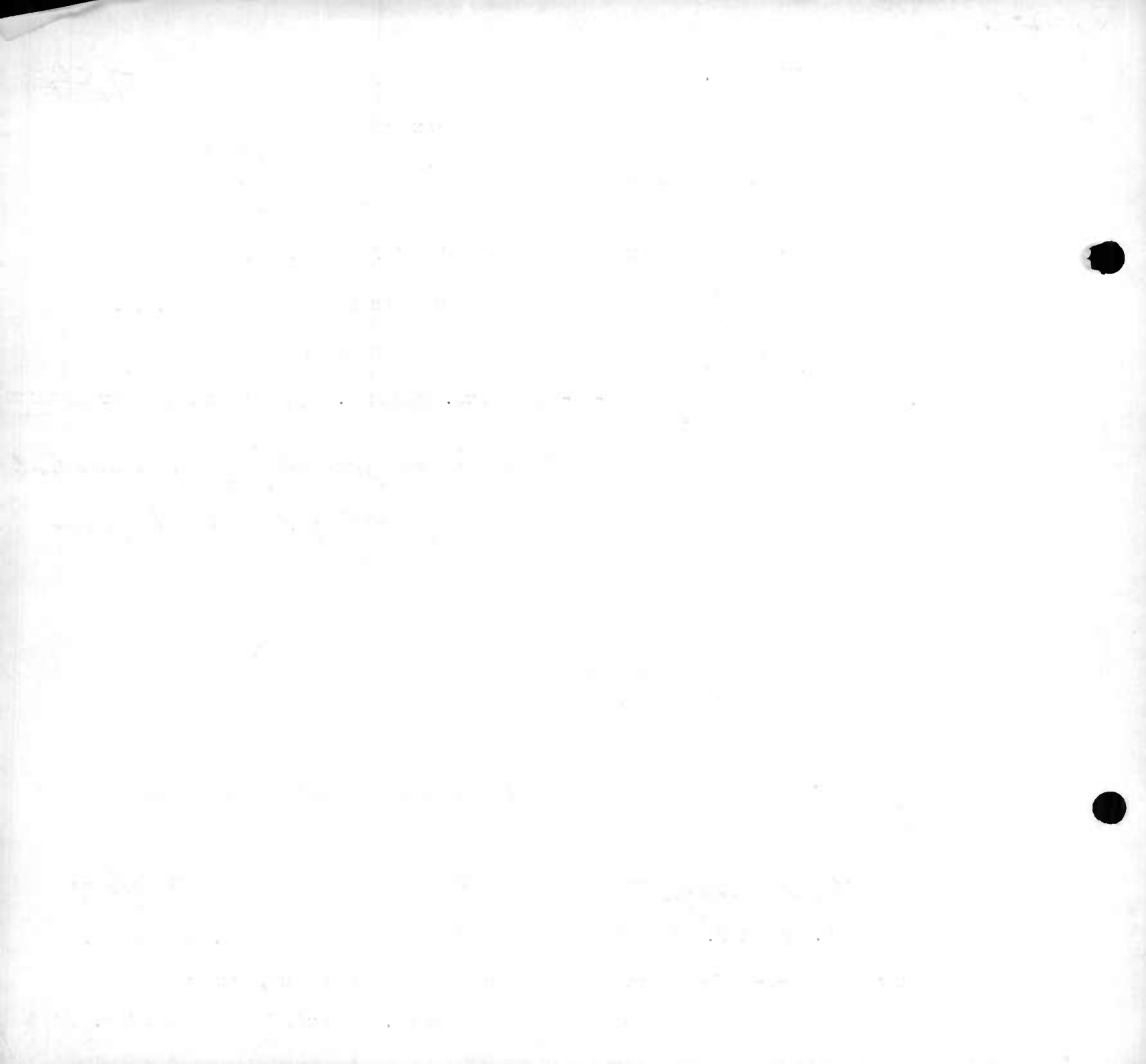
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

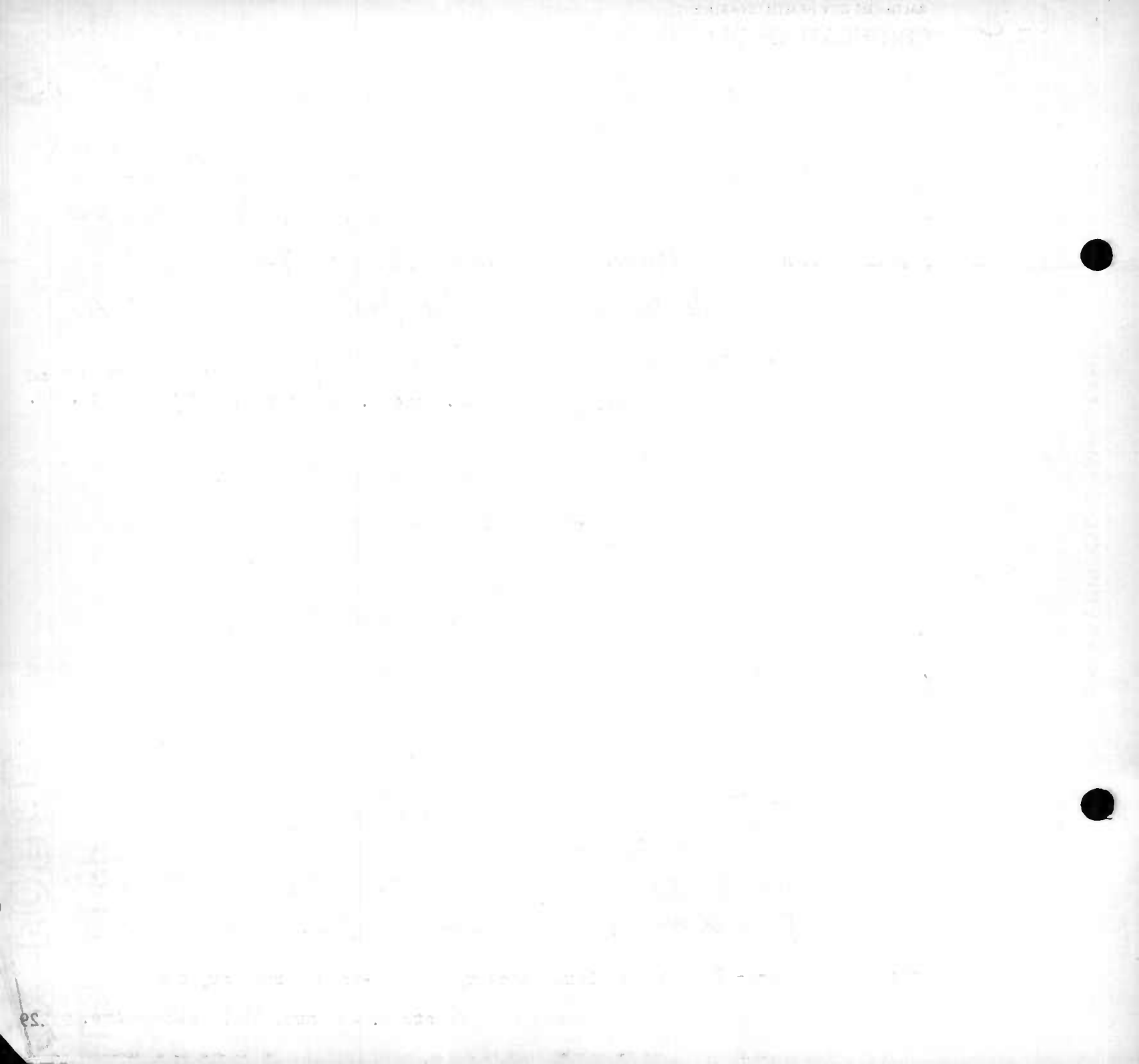
BIRTH NO.		67 6472		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6472	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
OTIS C. BOYCE				June 30, 1967		7:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland			
1840 Ramsey Street				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1840 Ramsey Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months: Days:		11. If Under 24 Hrs. Hours: Min.
Male	White	Married	July 2, 1915	51			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					North Carolina		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Milton Boyce				Viola Spivey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Yes.			226-16-9738		Mrs. Violet B. Ney, 312 Wessling Circle 21228		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) acute myocardial infarct DUE TO		immediate	
				(B) Coronary Artery Disease DUE TO		1 year	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 19 JULY 1966 to 30 JUNE 1967, that (1) (we) last saw the deceased alive on 30 JUNE 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Walter R. Welzant				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/3/67	
23C. PHYSICIAN'S NAME (Type) Dr. Walter R. Welzant				23D. ADDRESS 422-25 Medical Arts Bldg. Balto., Md. 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-1967		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6473</u>	
BIRTH NO. <u>67 6473</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type and Print) <u>Williamson, Frank M.</u>		2. DATE AND HOUR OF DEATH <u>7-3-67</u> <u>11<sup>15</sup></u> <u>P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>North Charles General Hospital</u>		C. CITY OR TOWN (If outside city limits, give RURAL and give township) <u>Baltimore</u>			
5. SEX <u>Male</u>		6. RACE <u>Wh</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	
8. DATE OF BIRTH <u>12-26-1891</u>		9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Williamson, Andrew</u>	
14. MOTHER'S MAIDEN NAME <u>Say, Mary</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-4690</u>	
17. INFORMANT <u>Mrs. Ella E. Williamson,</u>		6246 Woburn Road Lithicum Hgts. Md.		18. <u>493 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <u>Septicemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pneumonia</u>	
19. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>6/16</u> 19 <u>67</u> to <u>7-3</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-3</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>F. Hubbard</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-3-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Fildman</u>		23D. ADDRESS <u>1 Cherry Hill Road</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-7-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6474		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6474	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PROWZNIK, RICHARD		2. DATE AND HOUR OF DEATH JULY 3, 1967 2:24P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore Co.			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
40		D. STREET ADDRESS (If rural, give location) 4420 ALAN DRIVE 21229			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/24/43	9. AGE (In years lost birthday) 23	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIR CONDITION		10B. KIND OF BUSINESS OR INDUSTRY FROSTY REFRIGERATION		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN PROWZNIK		14. MOTHER'S MAIDEN NAME LEONA GEIGER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 219-38-5004		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) encephalomalacia		CAUSE OF DEATH (A) DUE TO hemorrhage right cerebral hemisphere (B) DUE TO clipping cerebral aneurysm (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 3 19 67 to JULY 3 19 67, that (I) (we) last saw the deceased alive on JULY 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jaime V. Del Pilar				23B. DATE SIGNED 7/3/67	
23C. PHYSICIAN'S NAME (Type) JAIME V. DEL PILAR				23D. ADDRESS ST. AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-1967		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1967			
25B. NAME OF REGISTRAR Robert E. Fashy, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6475	
BIRTH NO. 67 6475		<b>CERTIFICATE OF DEATH</b>		July 3, 1967 8:30 A.M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Ray I. Strough Sr.</b>		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Dundalk</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 Maryland General Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>3005 Dunmurry Rd.</b>		53-00	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11/2/02</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welding Engineer,</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Arcrods Co.</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Carlos Strough</b>		14. MOTHER'S MAIDEN NAME <b>Anna Nelliger</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>074-03-1407</b>		17. INFORMANT (Wife) <b>Dundalk, Md.</b> <b>Mrs. Mary Strough, 3005 Dunmurry Rd.</b>	
18. <b>199.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Hemorrhage</b> DUE TO (B) <b>Squamous cell Ca Tongue + pharynx, right</b> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>20 mos</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10 Dec 1965</b> to <b>present</b> 19 <b>67</b> , that (I) <del>was</del> last saw the deceased alive on <b>30 June</b> 19 <b>67</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Arthur G. Siwinski</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>7/3/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Arthur G. Siwinski</b>		23D. ADDRESS <b>836 Park Ave. Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/6/67</b>	24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JUL 6 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>	

Manuscript  
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18th century  
20ms

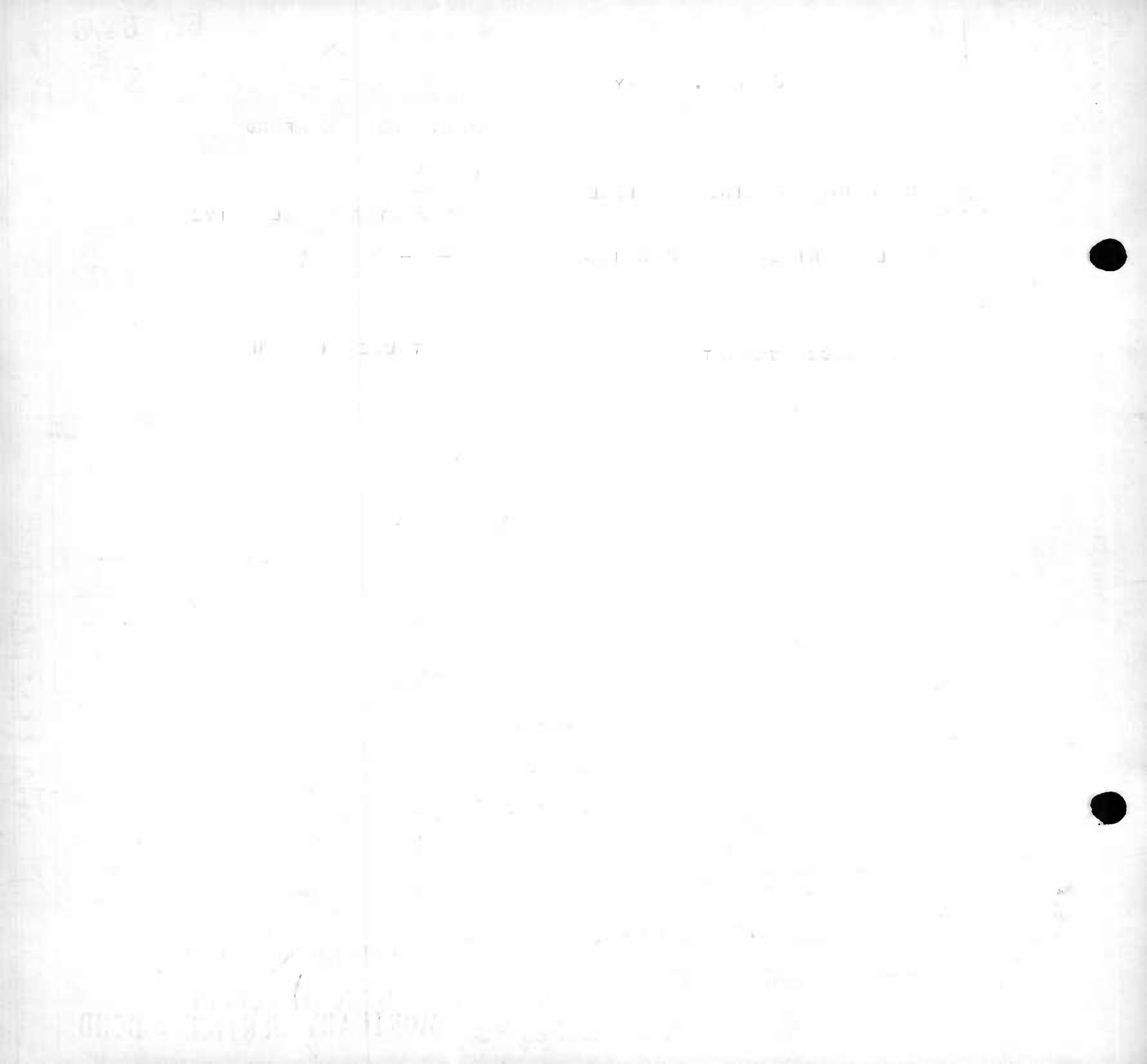
18th century

Manuscript

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6476	
BIRTH NO. 67 6476		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JEAN W. OSKAY		2. DATE AND HOUR OF DEATH 6-28-67 1 815 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY HARFORD		C. CITY OR TOWN (If outside city limits, write RURAL and give township) JOPPA	
33 THE JOHNS HOPKINS HOSPITAL		D. STREET ADDRESS (If rural, give location) 201 FOSTER KNOLL DRIVE		62-00	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 01-07-20	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME LAWRENCE STEWART			14. MOTHER'S MAIDEN NAME GERTRUDE SIMPSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) METASTATIC CA - INVADITION (B) CA COLON (C)		INTERVAL BETWEEN ONSET AND DEATH 2 YRS 1963	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 9th 1967 to JUNE 28th 1967, that (I) (we) last saw the deceased alive on JUNE 28th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE (Signature)		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-28-67	
23C. PHYSICIAN'S NAME (Type or Print) RAINER M. ENGBEL		M.D. 23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) JUN 30 1967		24B. DATE		24C. NAME OF CEMETERY (Specify) ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1967		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL HOME (Specify) UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	
				ADDRESS	



B-652

BIRTH NO. 67 6477

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GERALD BARNES

2. DATE AND HOUR PRONOUNCED DEAD July 5, 1967 6:50 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-34

D. STREET ADDRESS (If rural, give location) 509 Horners Lane

40 St. Agnes Hospital

5. SEX Male

6. RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH August 1, 1931

9. AGE (In years last birthday) 35

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber

11. BIRTHPLACE (State or foreign country) New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Leo Barnes

14. MOTHER'S MAIDEN NAME Elizabeth McGregor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Korean

16. SOCIAL SECURITY NO. 091-24-0411

17. INFORMANT ADDRESS Elizabeth Barnes - wife - same # 4 above

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO Craniocerebral injuries

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Road

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Maryland Rte. 32 3,000 ft. East of Berger Rd. 63-00

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 7 1 67 9:55 p.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? cycle accident

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED July 5, 1967

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE July 7, 1967

23C. NAME of CEMETERY or CREMATORY Rockville Cemetery

23D. LOCATION (City, town, or county) (State) Rockville, Montgomery, Md.

24A. DATE REC'D BY HEALTH DEPT. JUL 7 1967

24B. NAME OF REGISTRAR Robert E. Fisher

24C. FUNERAL DIRECTOR ADDRESS Tyson Wheeler Funeral Home 1331 Rockville Pk. Rockville, Md.

WILLIAM H. O'NEILL  
MILLEN PAPER

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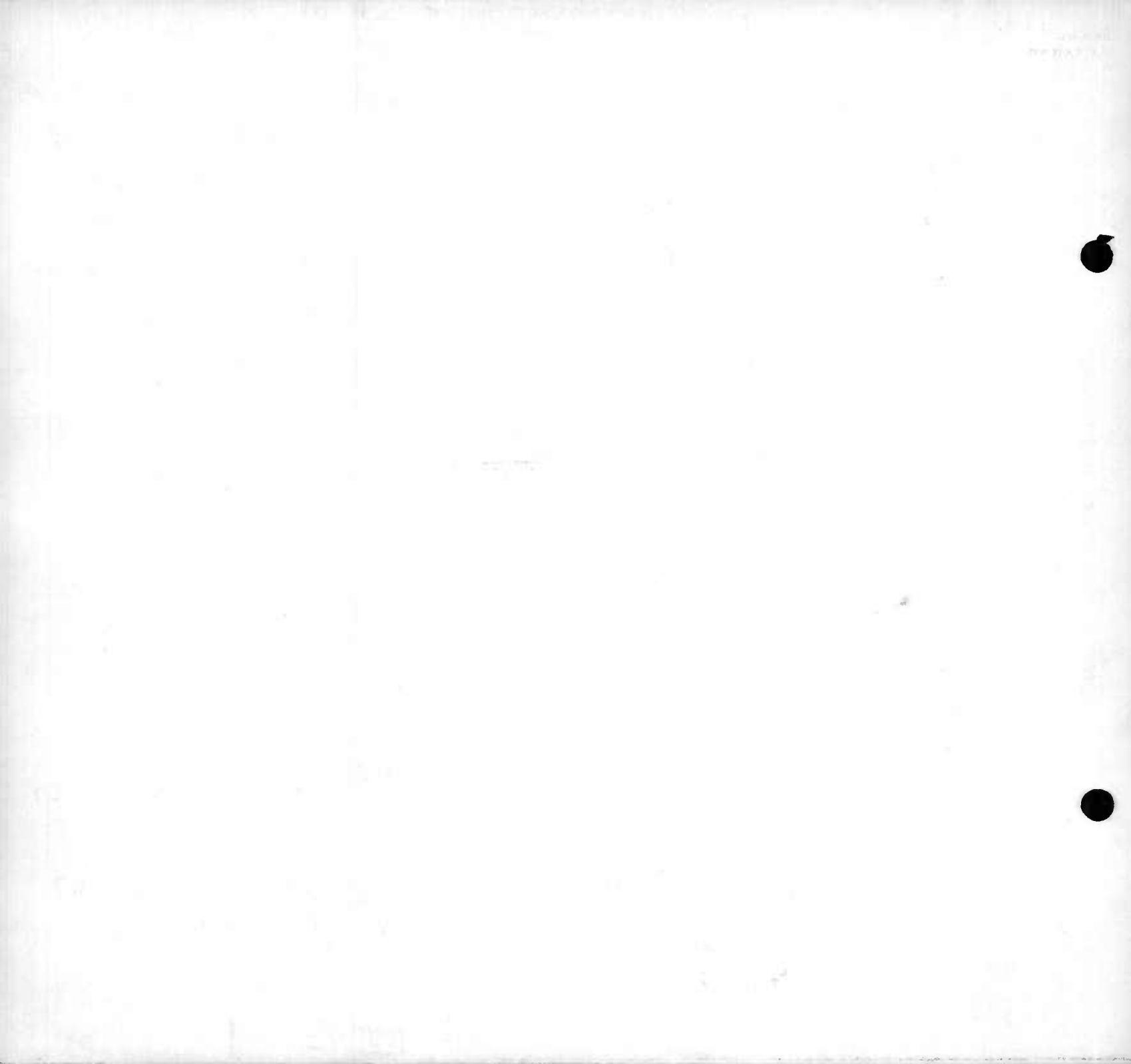
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 67 6478	
BIRTH NO. 67-12094 67 6478		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Baby Boy Williford</b>		2. DATE AND HOUR OF DEATH <b>6-23-67 11:07A.</b>	
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>G.A.C.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>43 South Baltimore General Hosp.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>GLEN BURNIE 52-00</b>			
D. STREET ADDRESS (If rural, give location) <b>304 3rd. AVE. S.E.</b>				5. SEX <b>M.</b> 6. RACE <b>White</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEW BORN</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>6-22-67</b>		9. AGE (In years last birthday) <b>NEW BORN</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Richard</b>				14. MOTHER'S MAIDEN NAME <b>E/ve Tolley</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <b>726X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>IM PREMATURITY</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>6-22</b> 19 <b>67</b> to <b>6-23</b> 19 <b>67</b> , that <del>it</del> (we) last saw the deceased alive on <b>6-23</b> 19 <b>67</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>William J. Marek</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6-23-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>William J. Marek</b>				23D. ADDRESS <b>121 ANTONY/BOASIDE NEW MEXICO</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>6-27-67</b>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 7 1967</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>	



B-652

67 6479

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65-11077 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6479

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>STACEY BARNES</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>July 4, 1967</b>   <b>9:50 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>15-12</b> D. STREET ADDRESS (If rural, give location) <b>2550 Druid Park Drive</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>5/2/1965</b>	9. AGE (In years last birthday) <b>2 Yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto Md</b>		
13. FATHER'S NAME <b>John G. Barnes</b>			14. MOTHER'S MAIDEN NAME <b>Mildred Barnes</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mildred Barnes-2550 Park Dr.</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>2812.4</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) Hemoperitoneum</b> <b>(B) Gastric and hepatic lacerations</b> <b>(C) Fracture of left temporal bone and left humerus</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>7/8/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Druid Park Dr. West of Hillside Pl.</b>			
21D. TIME OF INJURY (APPROX.) <b>7 3 '67 7 a.m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Pedestrian struck by auto 15-12</b>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher</b>			M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>July 5, 1967</b>		
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>7/8/67</b>		23C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem Balto Md</b>		23D. LOCATION (City, town, or county) (State)	
24A. DATE REC'D BY HEALTH DEPT. <b>JUL 7 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Farley M.D.</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Earl Gilmore-1827 W. North Ave</b>			

1911

2/2/1911

Letter to

Mr. B. B. B.

Mr. B. B. B.

John B. B.

Letter 7/18/11 Mr. B. B. B.

T-460

67 6480

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6480

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT TYLER

2. DATE AND HOUR PRONOUNCED DEAD

June 12, 1967

3:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

91 Montebello State Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

318 Pearl Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)  
35If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Pneumonia complicating spinal cord  
injury due to dislocation of cervical  
spineINTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

318 Pearl Street

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

9-4-65

?

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Assaulted by, or in fight with, two  
unidentified men

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 12, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

6-23-67

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 7 1967

Robert E. Farber, M.D.

MORTUARY SERVICE - BCHD

WALTER HOFER  
QUALITY PAPER  
95% GAS PERCENT

B-630

67 6481

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6481

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RUTH BARRETT

2. DATE AND HOUR PRONOUNCED DEAD

5-31-67

12:30 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1519 PARK AVENUE - Amb. Crew #4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1519 Park Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Subarachnoid and intracerebral hemorrhage  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Ruptured Berry aneurysm  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK

NOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D. ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-31-67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

6-23-67

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 7 1967

Russell S. Fisher, M.D.

MORTUARY SERVICE - BCHD

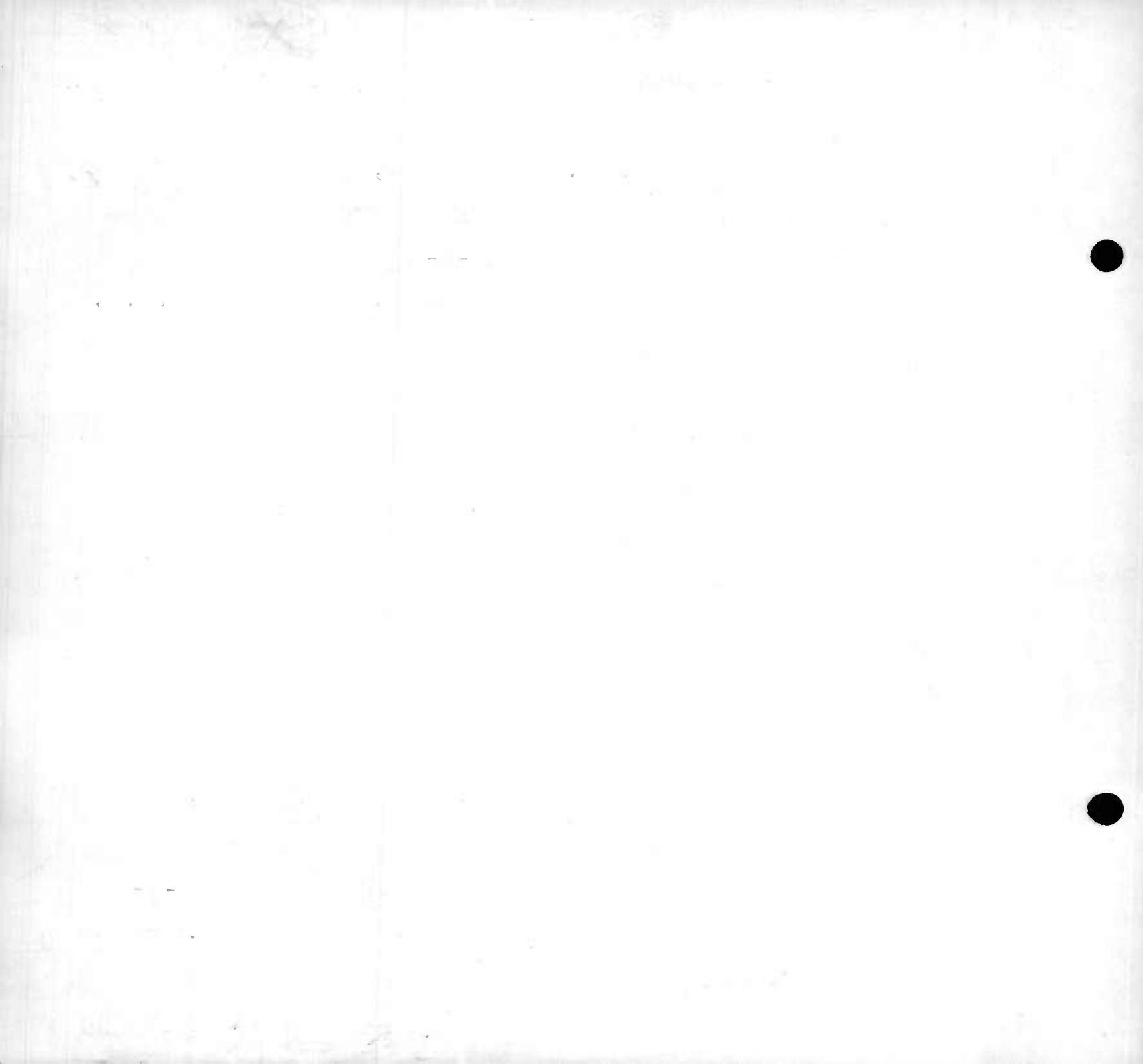
WALLACE & JONES



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-09447 67 6482		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6482	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Baby <sup>Boy</sup> <del>of</del> Helois Gumby Twin # 2			2. DATE AND HOUR OF DEATH May 24, 1967 4:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217			A. STATE B. COUNTY Maryland 13-04		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore,			D. STREET ADDRESS (If rural, give location) 2838 Parkwood Avenue 2838		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	B. DATE OF BIRTH 5-22-67	9. AGE (In years last birthday)	If Under 1 Yr. Months Days 2 14
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Lynwood Malone			14. MOTHER'S MAIDEN NAME Gumby		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Helois Gumby		ADDRESS SAME
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Prematurity DUE TO Hyaline membrane and hemorrhage (B) DUE TO of lungs (C)		
INTERVAL BETWEEN ONSET AND DEATH					
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 22, 19 67 to May 24, 19 67, that (I) (we) last saw the deceased alive on May 24, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Manuel G. Mercado</i>				23B. DATE SIGNED 5-29-67	
23C. PHYSICIAN'S NAME (Type) Manuel G. Mercado		23D. ADDRESS M.O. 1514 Division Street Balto., Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) 6-26-67		24B. DATE		24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1967		25B. NAME OF REGISTRAR R. E. Finkbeiner		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	
25D. ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

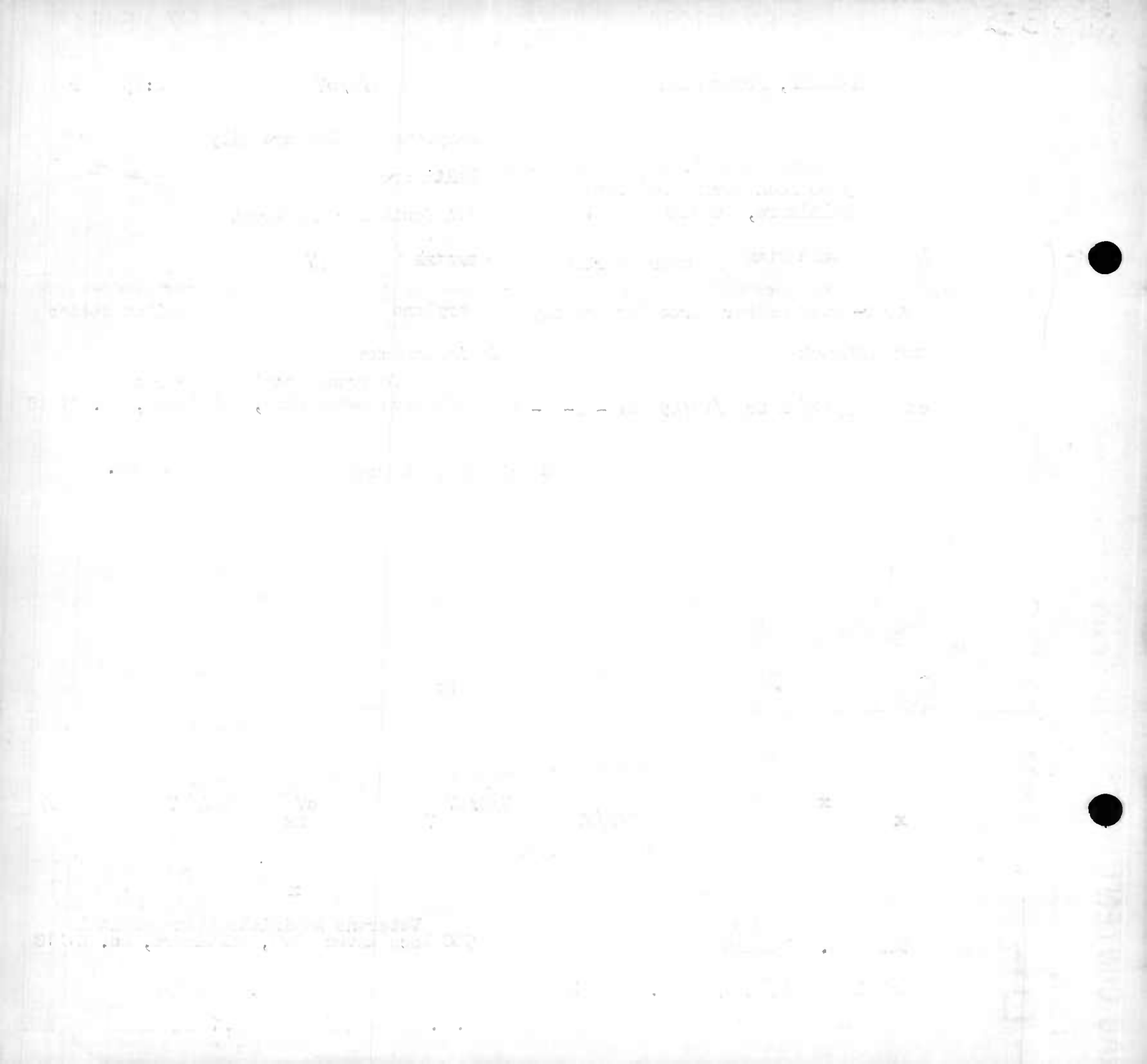
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BIRTH NO. <u>67 12255</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 6483</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BABY BOY</u>		2. DATE AND HOUR OF DEATH <u>JUNE 27-1967</u>   <u>2 35</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>21202</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 CHURCH HOME &amp; HOSPITAL</u>		D. STREET ADDRESS (If rural, give location) <u>1305 VALLEY ST</u>		9-09	
5. SEX <u>MALE</u>	6. RACE <u>COLORED</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>—</u>	8. DATE OF BIRTH <u>6-27-1967</u>	9. AGE (In years last birthday) <u>NEWBORN</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>55</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		13. FATHER'S NAME <u>JOHN LEE NIXON</u>		14. MOTHER'S MAIDEN NAME <u>ALICE HARVEY SOMERVILLE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>Mrs. Alice H. Nixon - 1305 Valley St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>724X1</u>		CAUSE OF DEATH (A) <u>Cardio - Respiratory Arrest</u> DUE TO (B) <u>Immaturity</u> DUE TO (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>L. Paragon</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/27/67</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>—</u>		24B. DATE <u>6-29-67</u>		24C. NAME of CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>John E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>JOHNS HOPKINS MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u>	



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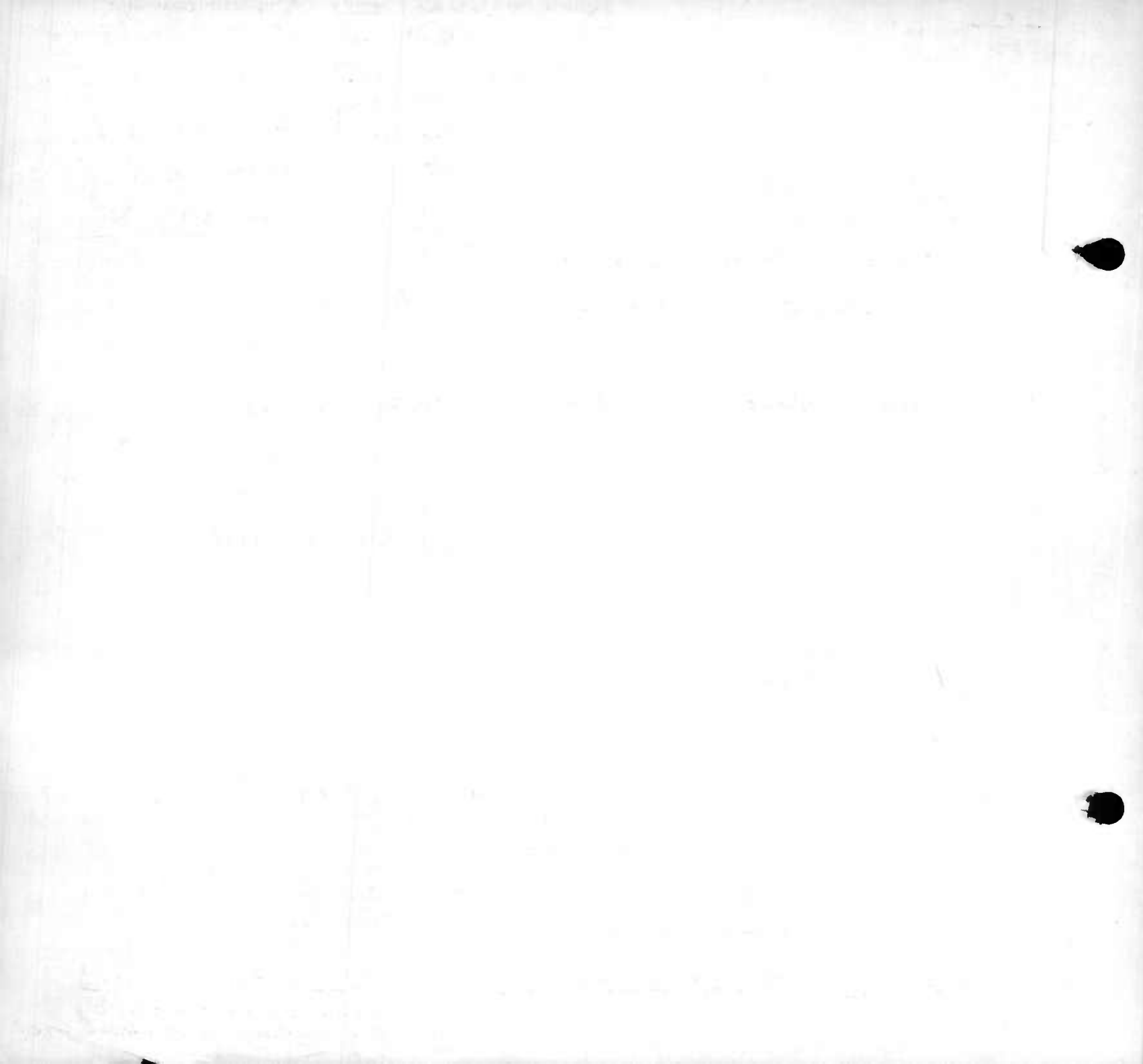
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6484</b>	
BIRTH NO. <b>67 6484</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>KMIOTEK, Frank John</b>		2. DATE AND HOUR OF DEATH <b>7/4/67 12:35 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore City</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>27 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>514 South Durham Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>7/16/09</b> <del>7/5/24</del>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Truck Helper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Trucking Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Henry Kmiotek</b>		14. MOTHER'S MAIDEN NAME <b>Julia Sawicka</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3/11/42 to 8/17/45</b>		16. SOCIAL SECURITY NO. <b>218-05-60-04</b>		17. INFORMANT <b>Veterans Hospital Records</b> <b>3900 Loch Raven Blvd, Baltimore, Md. 21218</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>163 X I</b> <b>Carcinoma Left Lung</b>		CAUSE OF DEATH (A) <b>Carcinoma Left Lung</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 Mos.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>10</del> (this hospital) attended the deceased from <b>7/3/67</b> to <b>7/4/67</b> 19 <b>67</b> that <del>1</del> (we) last saw the deceased alive on <b>7/4/67</b> 19 <b>67</b> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>1</del> (We) (did) (not) view the body after death.					
23A. SIGNATURE <b>R. A. Twining</b>				23B. DATE SIGNED <b>July 4, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>RALPH A. TWINING</b>		23D. ADDRESS M.D. <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd, Baltimore, Md. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/8/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUL 7 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 61-12938 67 6485				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 34-92-46 67 6485	
1. NAME OF DECEASED (Type or Print) <b>BRIAN KIETH DIAZ</b>				2. DATE AND HOUR OF DEATH <b>7.4.67 11.15 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>38 University Hospital</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel Co.</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Glen Burnie, Md. 52-00</b>			
				D. STREET ADDRESS (If rural, give location) <b>404 B. Pamela Rd</b>			
5. SEX <b>MALE</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>6.26.67</b>	9. AGE (In years last birthday) <b>8</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Paul Diaz</b>				14. MOTHER'S MAIDEN NAME <b>Jeanne E. Esmond</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>Hospital Records</b>			
18. <b>754.21</b> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO <b>Congenital Heart Disease</b>			
ANTECEDENT CAUSES				(B) DUE TO <b>Ventricular Septal Defect</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <b>atrial Septal Defect</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>6.29.67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>(cardiac cath) CHD</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6.28.1967</b> to <b>7.4.1967</b> , that (I) (we) lost saw the deceased alive on <b>7.4.1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Misbah Khan</b> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>7.4.67</b>	
23C. PHYSICIAN'S NAME (Type) <b>MISBAH KHAN</b> M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7-6-67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN</b>		24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 7 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>GEO. L. Schwab</b> ADDRESS <b>Funeral Home Francis W. Miller 2101 Frederick Ave</b>			

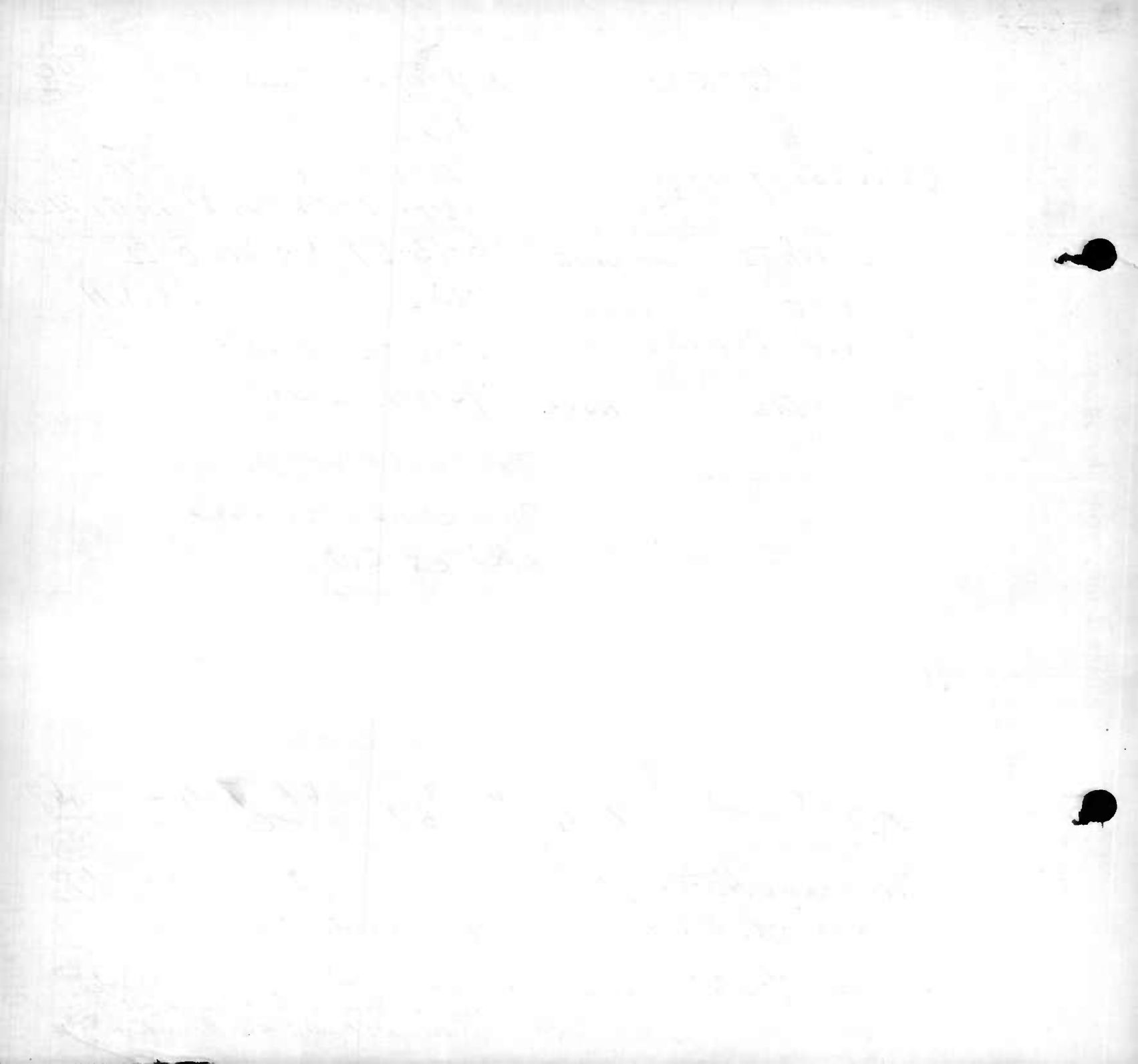




FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67-11998 67 6486		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6486	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
CROCKETT BABY BOY		JUNE 5/67 2:46 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
UNIVERSITY of MARYLAND HOSPITAL		MD			
38		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE 23-31			
		D. STREET ADDRESS (If rural, give location)			
		4644 PARKTON ST. BALTO 21229			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	NONE	6-13-67	New Born	0 22
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY	
NONE		NONE	MD	U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		ADDRESS	
Richard CROCKETT		LORETTA M. RADSKY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		
NO NONE		NONE	FATHER + MOTHER		
18. 756.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
		TRACHED ESOPHAGEAL FISTULA			
		BILATERAL PNEUMONIA			
		APCITES C.U.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
6-14/6-29/67		TET CRUG.			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-13-1967 to 7-5-1967, that (I) (we) last saw the deceased alive on 7/5-1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Francisco M. Sandoval M.D.				7/5/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Francisco M. Sandoval M.D.				University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-6-67		Holy Redeemer	
				Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR'S ADDRESS	
JUL 7 1967		Robert E. Fink M.D.		650 W. Second St. Baltimore	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-13371		67 6487		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6487	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
JOHN BURTON DOMBROSKY				2. DATE AND HOUR OF DEATH July 3, 1967 8 <sup>25</sup> P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
33 THE JOHNS HOPKINS HOSPITAL				BALTIMORE 28-04			
D. STREET ADDRESS (If rural, give location)				5108 GREENWICH AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD	8. DATE OF BIRTH 7-2-67	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Baltimore, Md.			
13. FATHER'S NAME THOMAS				14. MOTHER'S MAIDEN NAME DALE BURTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				Thomas Dombrowsky		5108 Greenwich Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH CARDIAC ARREST CONGENITAL HEART DISEASE Post CARDIAC CATHETERIZATION			
INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 7/3/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED POSSIBLE TRANS POSITION		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 3 1967 to July 3 1967, that (I) (we) lost the deceased alive on July 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stephen H. Polmar				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 3, 1967	
23C. PHYSICIAN'S NAME (Type) Stephen H. Polmar				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/1967		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1967		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Raymond C. Fink		ADDRESS Glen Burnie, Md	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67-12715 67 6488</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 6488</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>Baty - Gal Bland (BLAND)</b>		2. DATE AND HOUR OF DEATH <b>7-4-67 3:30 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St Bon Secours Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>23 - N</b> B. COUNTY <b>Monroe St. Md</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baeto 20-01</b>			
		D. STREET ADDRESS (If rural, give location) <b>23 N MONROE St</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>—</b>		8. DATE OF BIRTH <b>7-4-67</b>	9. AGE (In years lost birthday) <b>1</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Robert Bland</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Miller</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT ADDRESS <b>Hospital Recd -</b>	
18. <b>762-51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Atelctasis, severe</b> <b>Prematurity</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-4-67</b> 19 to 19 that (I) (we) last saw the deceased alive on <b>7-4-67</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Aleyde A. Melocoton M.D.</b>				23B. DATE SIGNED <b>7-4-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALEYDE A MELOCOTON M.D.</b>				23D. ADDRESS <b>Bon Secours 2025 W Fayette St</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/5/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St Peters Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Baeto Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 7 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Thomas J. Kenney Inc Baeto</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-12740 67 6489		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6489	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BABY GIRL SCOTT</b>		2. DATE AND HOUR OF DEATH <b>6-30-67 7<sup>30</sup> A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 28-03</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPITAL</b>		D. STREET ADDRESS (If rural, give location) <b>5116 FRANKLINTOWN ROAD</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>—</b>	8. DATE OF BIRTH <b>6-28-67</b>	9. AGE (In years lost birthday) <b>37</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <b>4</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>—</b>		13. FATHER'S NAME <b>RUSSELL JACKIE BOBST</b>		14. MOTHER'S MAIDEN NAME <b>SIBIRLEY SCOTT</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Hospital Info</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>762.51 Prematurity</b>		CAUSE OF DEATH (A) DUE TO <b>Prematurity</b> (B) DUE TO <b>Fracture</b> (C) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>6/1/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>—</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>6/1/67</b> 19 <b>67</b> to <b>6/30</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/30</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Chang Ky Bae</b> M.D.				23B. DATE SIGNED <b>6/30/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Chang Ky Bae</b> M.D.				23D. ADDRESS <b>2025 W Fayette Bon Secours Ho</b>	
24A. BURIAL-CREATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/1/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>St Peter's Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		25A. DATE REC'D <b>JULY 1 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, Md</b>		25C. FUNERAL DIRECTOR <b>Thomas J. Kennedy</b>			
ADDRESS <b>Baltimore Md</b>		ADDRESS <b>Baltimore Md</b>			

W. H. H. H.

Chap. 17. The History of the  
County of York, N. Y.  
from 1614 to 1800.



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G-613

67 6490 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6490

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
VIRGINIA P. GRIFFITH		7-5-67 5:45 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland	
42 SINAI HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 5515 Groveland Avenue 21215	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Female	White	Married	Feb. 11, 1919
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
Waitress		Restaurant	48
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
California		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Gordon Kaplinger		Dorothy Pearce	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no		unknown	
17. INFORMANT		ADDRESS	
Mrs. Dorothy Kaplinger (mother)		Oak Grove, Virginia	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
(A) Chronic pulmonary emphysema DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type) CHARLES S. SPRINGATE, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	7-6-67
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	23C. NAME of CEMETERY or CREMATORY
Burial		July 9/67	Oak Grove Cemetery
23D. LOCATION (City, town, or county) (State)		23E. FUNERAL DIRECTOR	
Oak Grove, Virginia		Singleton Funeral Home	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
JUL 7 1967		Robert E. Fisher, M.D.	
24C. ADDRESS		24D. ADDRESS	
Glen Burnie, Maryland		Glen Burnie, Maryland	

VS 151-REV. 1/1/65

WALLINGFORD POLICE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6491		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6491	
M.E. CASE NO.			1. NAME OF DECEASED		
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
CHARLES HARRIS			7-2-67 10 PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)		
BOLTON HILL NURSING CENTER			A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
90			PLAZA MANOR NURSING HOME		
			7355 FURNACE BRANCH Rd		
			D. STREET ADDRESS (If rural, give location)		
			GLEN BURNIE MD 52-00		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years)	10. Under 1 Yr. Months Days
MALE	Negro	WIDOWED, DIVORCED (specify)	3-28-1891	76	46
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				MD	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John E. Harris		Tempy Harris		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		8-30-062		Raymond Davis	
				ADDRESS	
				4815 B. St. Wash. D.C.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of death, heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II			Interval Between Onset and Death		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.			Fractured Hip		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
Unknown					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Unknown		Unknown	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
Unknown		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		Unknown	
22. I certify that (I) (this hospital) attended the deceased from June 16, 19 67 to July 2, 19 67, that (I) (we) last saw the deceased alive on July 2, 19 67 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				July 2, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
HARRIS		5519 KENNISON		In Baltimore Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7-5-67		Mt Zion	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 7 1967		Robert E. Taylor, MA		William Reese	
				ADDRESS	
				Cinna Md	

A21

RECEIVED

Mr. Jones  
12/1/22

12/1/22

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 6492 CERTIFICATE OF DEATH					Registered No. 67 6492				
BIRTH NO. 67 6492					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>DONOVAN, Avery Kinzer</b>					2. DATE AND HOUR OF DEATH <b>4 July 1967 11:45 A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University of Maryland Hospital Redwood and Greene, Balto</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Md. 53-00</b>				
D. STREET ADDRESS (If rural, give location) <b>910 Bardswell Rd.</b>									
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>1 Sept. 1898</b>	9. AGE (In years lost birthday) <b>68</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Avery Donovan</b>			14. MOTHER'S MAIDEN NAME <b>FDA Dawson</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>			16. SOCIAL SECURITY NO. <b>221-073142</b>		17. INFORMANT <b>wife Mr. Mildred D. same</b>				
I. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Septic Shock</b>					(A) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO <b>Peritonitis</b>				
					(C) DUE TO				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Atherosclerotic Abdominal Aortic Aneurysm</b>									
19A. DATE OF OPERATION <b>25 June 1967</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abdominal Aortic Aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office/bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>24 June 1967</b> to <b>4 July 1967</b> , that (I) (we) last saw the deceased alive on <b>4 July 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Santos, Ch. P.</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>4 July 1967</b>				
23C. PHYSICIAN'S NAME (Type) <b>Dellen S. Santos, M.D.</b> M.D.					23D. ADDRESS <b>Univ. of Md. Hosp.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7-7-67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HARBESON Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>HARBESON Delaware</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 7 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Herbert D. Shaw</b>		ADDRESS <b>Lawrence</b>			

University of Maryland Hospital  
Retired  
1200 1st St. N.E.  
Washington, D.C.

Robert's Shop  
Furniture

Address: 1200 1st St. N.E.  
Washington, D.C.

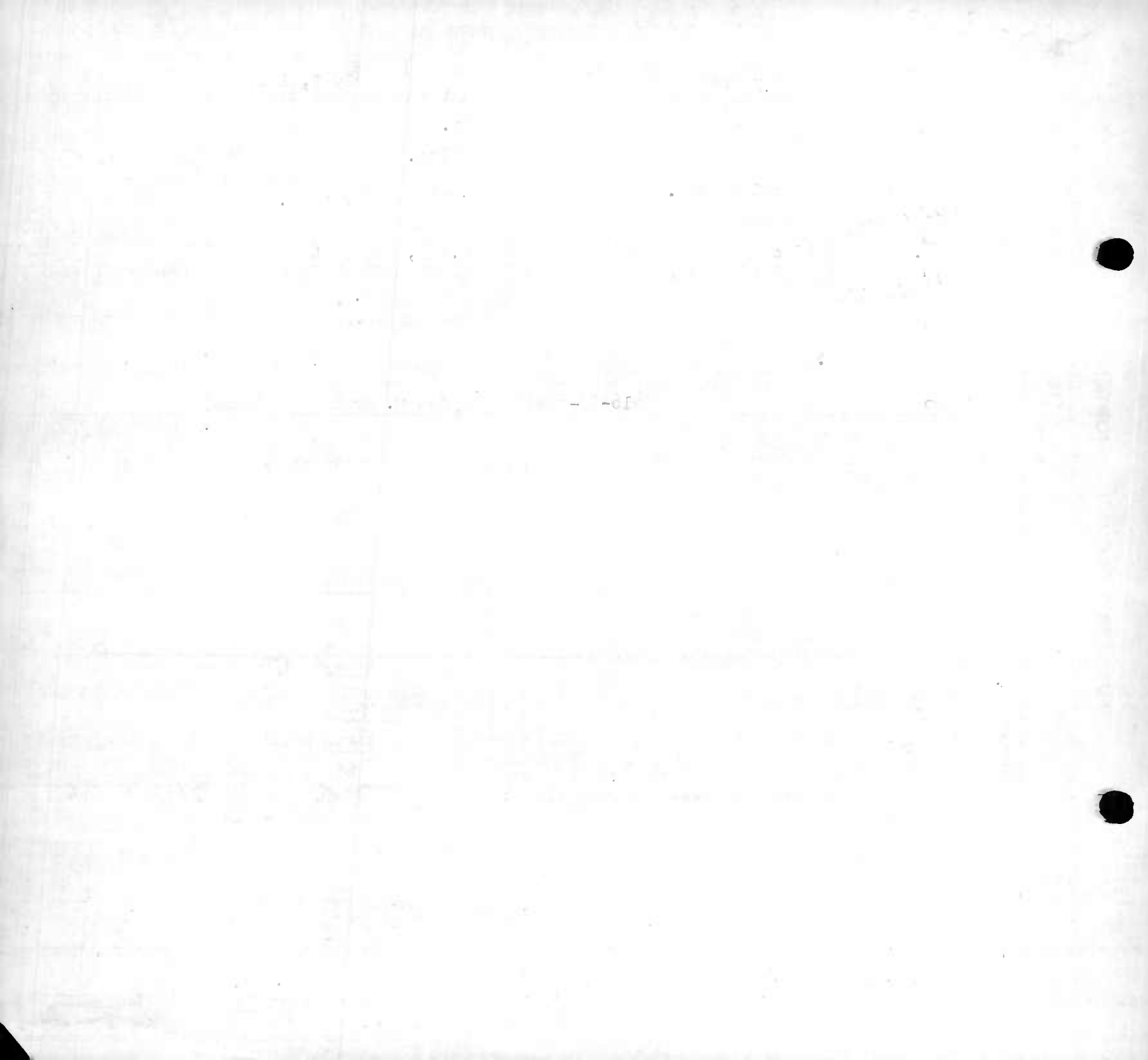
July 1st 1964

July 2nd 1964  
Chas. of W.D. Corp.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 6493				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 6493	
1. NAME OF DECEASED (Type or Print) <b>Mary Orem</b>				2. DATE AND HOUR OF DEATH <b>July 2, 1967</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>33 John Hopkins Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto.</b> D. STREET ADDRESS (If rural, give location) <b>2915 McElderry St.</b>			
5. SEX <b>Fe.</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 21, 1900</b>	9. AGE (In years lost birthday) <b>66</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-09-8099</b>		17. INFORMANT <b>Graydon C. Orem (same)</b>		ADDRESS	
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.)				CAUSE OF DEATH (A) <b>Coronary Thrombosis</b> DUE TO (B) <b>Generalized atherosclerosis</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19 64</b> to <b>7/2</b> 1967, that (I) (we) lost saw the deceased alive on <b>6/15</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>JULIUS H GOODMAN</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>7/3/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Julius H Goodman</b>		23D. ADDRESS <b>3400 E Baltimore Street</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/5/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. co.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 7 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Paul E. Chomicki</b>		ADDRESS <b>3617 Chestnut Ave</b>	





1  
H-635

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 6494 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6494

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) WILLIAM F. HARTMAN, Sr. 2. DATE AND HOUR PRONOUNCED DEAD July 5, 1967 | 2:10 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
5509 Garland Avenue Baltimore 26-01

D. STREET ADDRESS (If rural, give location) 5509 Garland Avenue

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED 8. DATE OF BIRTH SEPT. 23, 1912 9. AGE (In years last birthday) 54 If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST 10B. KIND OF BUSINESS OR INDUSTRY MIDDLEBURY MACHINE CO. 11. BIRTHPLACE (State or foreign country) BALTO. MD 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME HARRY J. HARTMAN 14. MOTHER'S MAIDEN NAME ELLEN M. CASHMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 212-077199 17. INFORMANT ADDRESS MRS. THERESA H. HARTMAN 5509 GARLAND AVE

18. E 976A I CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Gunshot wound of the head DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2-6-67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Home 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5509 Garland Avenue 26-01

21D TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7 5 67 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? Subject shot himself

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED July 5, 1967

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23B. DATE 7-8-1967 23C. NAME OF CEMETERY or CREMATORY MOPELAND MEMORIAL 23D. LOCATION (City, town, or county) (State) BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT. JUL 7 1967 24B. NAME OF REGISTRAR Robert E. Fisher, M.D. 24C. FUNERAL DIRECTOR ADDRESS J. Walter Conklin 5444 BELAIR RD.

WALTER PAUL

NEW YORK

1910

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6495</b>	
<div style="display: flex; justify-content: space-between;"> <span>B-6210</span> <span>67 6495</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)		Md.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male		White		Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Sanitation Worker		City Employee		9/10/1912	
13. FATHER'S NAME		11. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Willis Barrett		Lula Richmond		54	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		232-26-4666		Mrs. Anna Barrett	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Rheumatic Heart Disease		Since April 1, 65	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 6, 1965 to July 5, 1967, that (I) (we) last saw the deceased alive on June 23, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Morris B. Schreiber				7-6-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
MORRIS B. SCHREIBER		1519 W. Lombard St Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7/9/67		Lutheran Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 7 1967		Robert E. Taylor, Jr.		John J. Cowanston Inc.	
				ADDRESS	
				23. Md. Hollins St.	



## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 6496 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 6496

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH E. FOWLER

2. DATE AND HOUR PRONOUNCED DEAD

July 5, 1967 12:55 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

117 E. Ostend Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 22, 1903

9. AGE (In years  
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Seaman

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Prince Frederick, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Willie Franklin Fowler

14. MOTHER'S MAIDEN NAME

Mamie Helen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown, If yes, give war or dates of service)

Yes

Navy, 1920-1923

16. SOCIAL  
SECURITY NO.

253-20-4490

17. INFORMANT

ADDRESS

Mrs. Mildred K. Fowler, 117 E. Ostend St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular  
DUE TO Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

7-8-67

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

23D. LOCATION

(City, town, or county)

(State)

4300 Old Frederick Road, Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

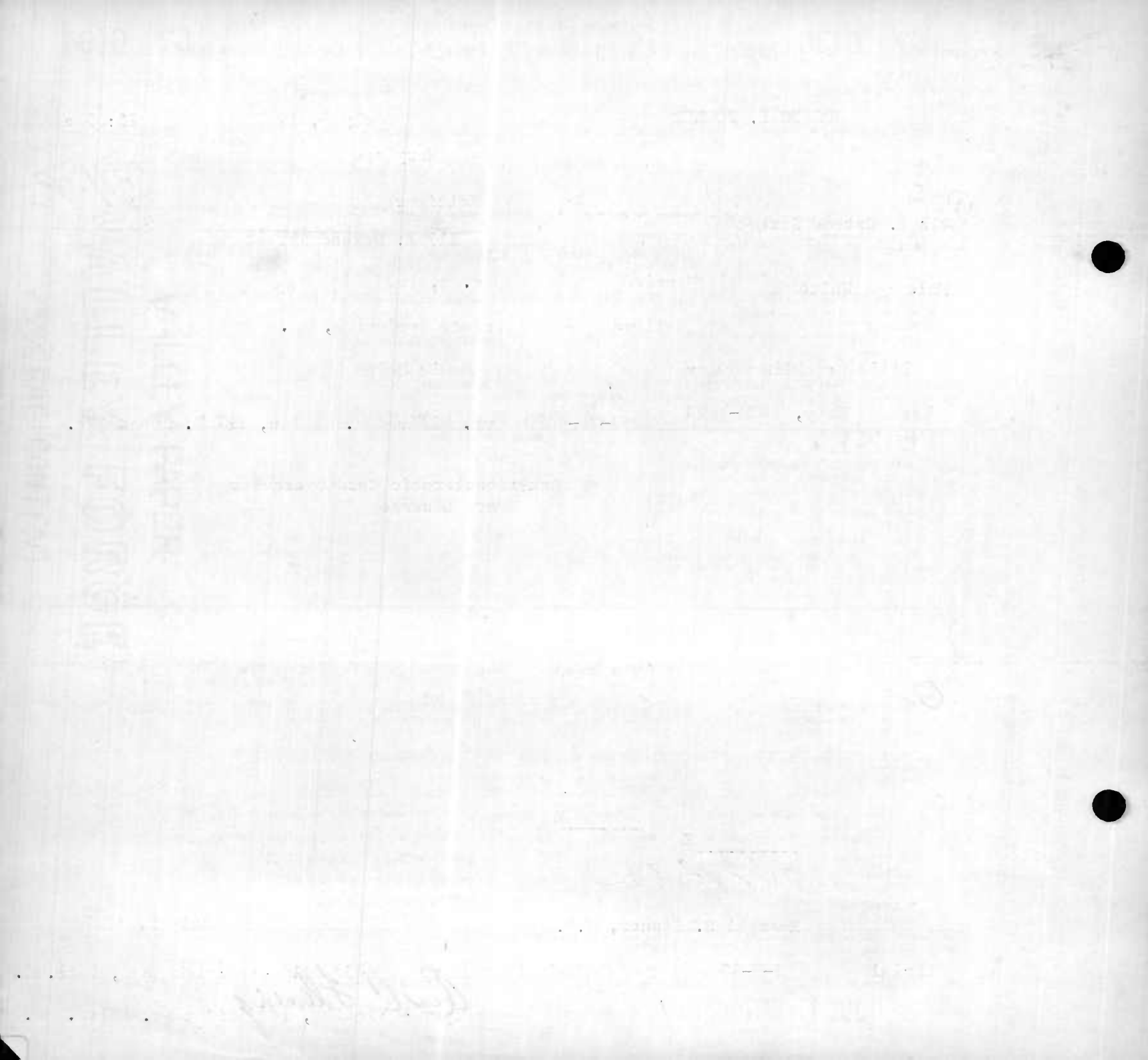
JUL 7 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Flynn &amp; Fleming, 1427 Light St. Balto. Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6497	
BIRTH NO. 67 6497		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BROWN, (BESSIE) (BETTY)</b>		2. DATE AND HOUR OF DEATH <b>7.2.1967 8.50 p.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b>		A. STATE <b>MD.</b> B. COUNTY <b>BALTO. Co.</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 53-00</b>			
		D. STREET ADDRESS (If rural, give location) <b>1927 BEECHFIELD AVE</b>			
5. SEX <b>F.</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARR.</b>	8. DATE OF BIRTH <del>7.2.1967</del>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JACOB MIDEN</b>		14. MOTHER'S MAIDEN NAME <b>BELLE ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-32-2675</b>		17. INFORMANT ADDRESS <b>MYER BROWN 1927 BEECHWOOD RD., BALTO., MD.</b>	
18. <b>4-20-1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute Pulmonary Edema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute Myocardial Infarction.</b> <b>ASCD</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>(No)</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7.2.1967</b> to <b>7.2.1967</b> , that (I) (we) lost saw the deceased alive on <b>7.2.1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Oscar E. Fernandez</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>7.2.67</b>	
23C. PHYSICIAN'S NAME (Type) <b>OSCAR FERNANDINI</b>		23D. ADDRESS <b>Lutheran Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7/4/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>GREATER BALTIMORE LODGE</b>	
				24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 7 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS 6010 REISTERSTOWN RD.</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 6498	
BIRTH NO. 67 6498		67 6498		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SARAH ROSENBERG		2. DATE AND HOUR OF DEATH 7/4/67 5:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-17	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE 42		D. STREET ADDRESS (If rural, give location) <del>XXXXXXXXXXXXXXXXXXXX</del> 5038 QUEENSBERRY AVENUE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12/19/32	9. AGE (In years lost birthday) 84	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) POLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME BULION		14. MOTHER'S MAIDEN NAME TOBA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT TILLIE ROSENBERG, 5038 QUEENSBERRY	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) GASTROINTESTINAL HEMORRHAGE DUE TO (B) CARCINOMA OF STOMACH DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/23/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED STOMACH		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/23/67 19 to 7/4 1967, that (I) (we) last saw the deceased alive on 7/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allan Land		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/4/67	
23C. PHYSICIAN'S NAME (Type) ALLAN LAND		23D. ADDRESS M.D. SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/5/67		24C. NAME OF CEMETERY or CREMATORY WORKMEN CIRCLE	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.			

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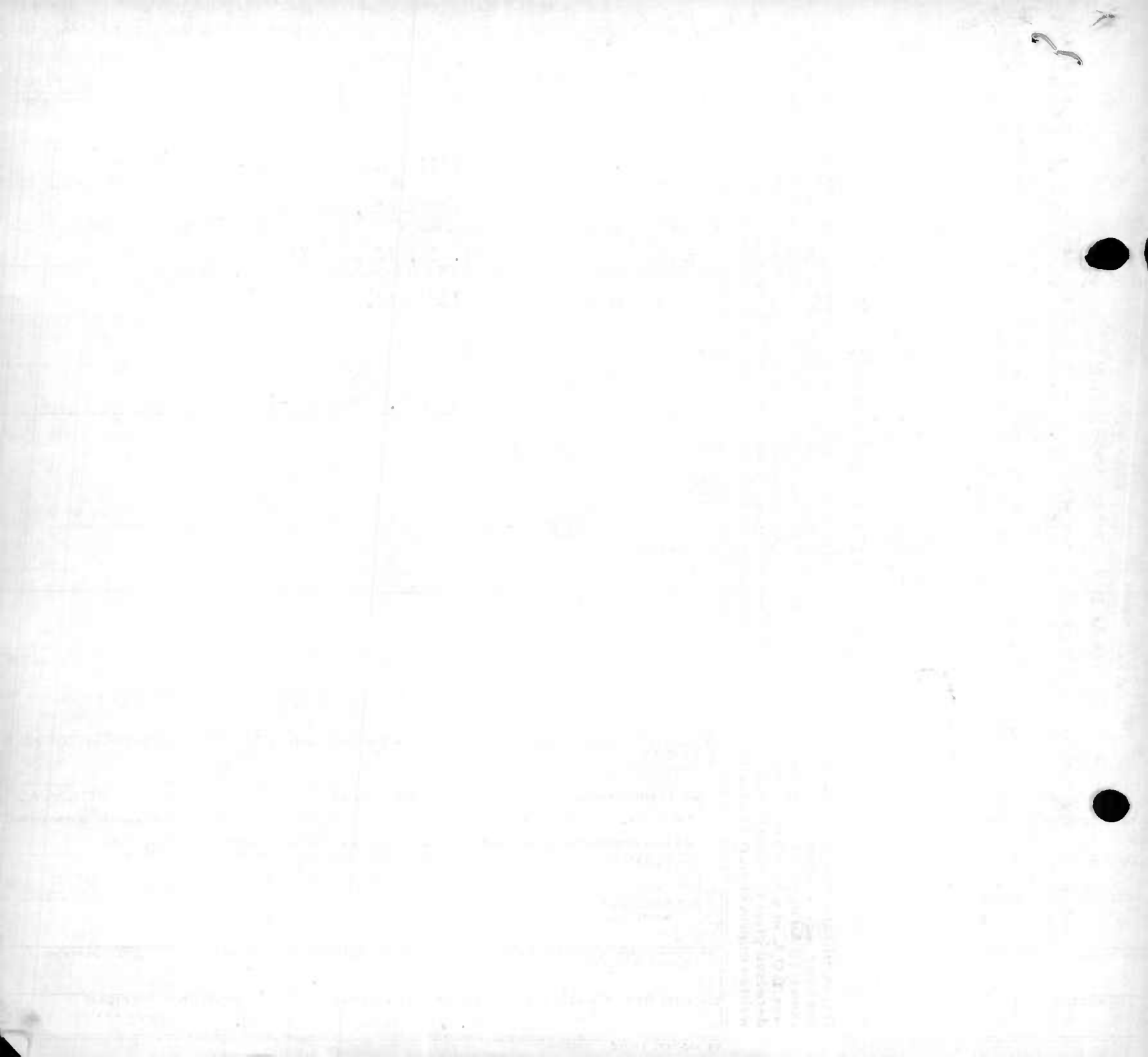
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 6499</u>	
BIRTH NO. <u>67 6499</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Bessie Chessler</u>		2. DATE AND HOUR OF DEATH <u>July 3, 1967</u> <u>1 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00</u> <u>Park Towers, East Apts.</u> <u>7111 Park Heights Avenue</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>7111 Park Heights Avenue Apt 408</u>			
		D. STREET ADDRESS (If rural, give location) <u>Baltimore, Maryland</u> <u>27-20</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 25, 1893</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Bernard Weinkranz</u>		14. MOTHER'S MAIDEN NAME <u>Sheba ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Richard D. Chessler-1602 Woodling Way</u> <u>4</u>	
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>acute myocardial infarction</u> DUE TO (B) <u>arterial cv disease</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 min - 5 yr +</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 62</u> to <u>July 3 19 67</u> , that (I) (we) last saw the deceased alive on <u>July 2 19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Maurice Feldman</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>7/3/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>MAURICE FELDMAN</u>		23D. ADDRESS <u>2 E READ ST</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 5/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hebrew Friendship</u>	
		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JULY 7 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Sol. Levinson &amp; Bros Inc. 6010 Reisterstown Rd</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 6500</b>	
BIRTH NO. <b>67 6500</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>PIKE, MR. JOHN H.</b>		2. DATE AND HOUR OF DEATH <b>7-5-67 7:45 pm</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME + HOSPITAL</b> <b>100 N. BROADWAY ST., BALTO, MD 21231</b>		D. STREET ADDRESS (If rural, give location) <b>721 N. CURLEY ST. #5</b>		7-01	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-5-95</b>	9. AGE (in years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done at home, in kind of business, or profession) <b>Plumbing Inspector</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>City of Balto.</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.-A.</b>		13. FATHER'S NAME <b>JAMES PIKE</b>		14. MOTHER'S MAIDEN NAME <b>SARA GERMAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>?</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Amy O. Pike, wife, above</b> <b>PATIENT</b> <b>SAME AS ABOVE</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>72011-163X</b>		CAUSE OF DEATH (A) <b>Acute Myocardial Infarction?</b> DUE TO (B) <b>Arteriosclerotic Cardiovascular Disease, Marked</b> DUE TO (C) <b>Chronic Pulmonary Emphysema, Marked</b> <b>D L L Carcinoma (Lung)</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>THORACOTOMY 7-5-67</b>			
19A. DATE OF OPERATION <b>7-5-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF LUNG</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-16</b> 19 <b>67</b> to <b>7-5</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7-5</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jose G. Ortiz</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>7-5-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSE G. ORTIZ</b>		23D. ADDRESS <b>Church Home + Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/8/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Memorial Park</b>	
24D. LOCATION <b>Maryland</b>		24E. ADDRESS <b>(City, town, or county) (State)</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 7 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taneyman</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home</b>	
25D. ADDRESS <b>2601-03-05 E. Madison Street #5</b>					

151 W. CHURCH ST.

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